Village Green DENTAL CARE

Medical History

Prefix (Mr./Mrs./Ms./Dr./Miss/Mstr.) _____ **Preferred Name:** _____

Birth Date: (mm/dd/yyyy) _____ **First Name:** _____

☐ Male ☐ Female **Last Name:** _____

Do you or have you had any of the following condi ons? Check all that apply.

- ☐ Heart A ack (When)? _____
- ☐ Stroke/TIA (When)? _____
- ☐ Angina/Chest Pain/Shortness of Breath
- ☐ Atrial Fibrilla on
- ☐ Heart Arrhythmia/Irregular Heartbeat
- ☐ Congenital Heart Disease
- ☐ Heart Valve Replacement/Repair
  (Type)? _____
  (When)? _____
- ☐ Pacemaker
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Ver go ☐ Faint/Dizzy Spells/Light-headedness
- ☐ COPD
- ☐ Asthma
- ☐ Sleep Apnea ☐ C-Pap Machine
- ☐ Cancer
  (Type)? _____
  (When)? _____
  ☐ Radia on ☐ Chemotherapy ☐ Surgery
  ☐ Ac ve Treatment ☐ Remission Since _____
- ☐ Diabetes ☐
  ☐ IDDM (Insulin Dependent)
  ☐ NIDDM (Non-Insulin Dependent)
  Average blood sugar range: _____
- ☐ Malignant Hyperthermia
- ☐ Drug/Alcohol Dependence ☐ Past ☐ Current
- ☐ Steroid Therapy _____
- ☐ Heartburn/Gastric Reflux
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Stomach Ulcers
- ☐ HIV/AIDS
- ☐ Hepa s ☐ A ☐ B ☐ C
- ☐ Autoimmune Disorder
  ☐ Mul ple Sclerosis
  ☐ Lupus
  ☐ Rheumatoid Arthri s
  ☐ Other _____
- ☐ Thyroid Disease ☐ Hypo Thyroid ☐ Hyperthyroid
- ☐ Chronic Neck/Back Pain
- ☐ Osteoporosis
- ☐ Seizures/Epilepsy
  Date of last seizure _____
- ☐ Blood Disorder (Ex: Anemia, Sickle Cell) _____
- ☐ ADD/ADHD
- ☐ Demen a
- ☐ Developmental Delay _____
- ☐ Au sm Spectrum Disorder
- ☐ Non-Verbal
- ☐ Depression/Anxiety
- ☐ Psychiatric Disorder _____
- ☐ Hearing Di culty/Impairment _____
- ☐ Glaucoma ☐ Closed/Narrow ☐ Open/Wide
- ☐ Glasses ☐ Contact Lenses ☐ Visually Impaired
- ☐ Requires Wheelchair Access
  ☐ Can transfer alone or with help
  ☐ Cannot Transfer

Have you had any surgeries, major illnesses or hospitaliza ons? ☐ Yes ☐ No

Please list:

Are you currently (or within the past 5 years) being treated for any medical condi ons or disease not listed above? ☐ Yes ☐ No

Please list:

When was your last physician visit (approximately)? _____

Do you have a prosthe c or ar ficial joint? ☐ Yes ☐ No

Loca on: _____

Date(s) of placement: _____

Have you ever had an organ transplant or implanted medical devices (ex: s mula on devices, screws, pins, etc.)? ☐ Yes ☐ No

Loca on: _____

Date(s) of placement: _____

Village Green DENTAL CARE

Medical History

Do you smoke or chew tobacco products? ☐ Yes ☐ No

If you quit using tobacco, when?

Do you use electronic cigarettes or a vaporizer? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Expected due date:

Are you breast feeding? ☐ Yes ☐ No

Do you have any allergies to medications? ☐ Yes ☐ No

Please list, along with reactions:

Do you have any other allergies? ☐ Yes ☐ No

Please list, along with reactions:

Do you have an allergy to latex? ☐ Yes ☐ No

Medications

☐ I have attached a list of my most recent medications.
☐ Please contact my pharmacy for my most recent list.

Pharmacy Name: _____
Location: _____
Phone: _____

Are you currently taking any medications? ☐ Yes ☐ No

(Prescriptions, patches, inhalers, vitamins, supplements, holistic or non-prescription drugs, including medical or recreational marijuana):
Please list:

Do you currently take any prescription blood thinners? ☐ Yes ☐ No

☐ Coumadin (Warfarin) ☐ Pradaxa (Dabigatran) ☐ Eliquis (Apixaban) ☐ Xarelto (Rivaroxaban ☐ Plavix (Clopidogrel)
☐ Other _____

Have you ever been treated for osteoporosis? ☐ Yes ☐ No

Please check the following medications you are currently taking or have taken:
☐ Fosamax, Fosavance (Alendronate) ☐ Didronel (Etidronate) ☐ Zometa, Reclast, Aclasta (Zoledronic Acid)
☐ Actonel, Atelvia (Risedronate) ☐ Other _____

Medication began: _____ Medication Discontinued: _____

Does dentistry/dental treatment cause you anxiety? ☐ Yes ☐ No

Please explain:

To the best of my knowledge, the above information is correct:

_____	_____	_____	_____
Patient/Parent/Guardian Signature	Name of Patient/Parent/Guardian (print)	Dentist Signature	Date