# Poudre Valley Family Dental

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**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Office only: Blood pressure:** _____

**Has there been any change in your health in the past 2 years?** ◯ Yes ◯ No

**If yes, please explain:**

_____

_____

**When was your last visit to a physician?** _____

**Name, address, phone number for Physician:**

_____

_____

**Do you need any special accommodations for dental treatment?** _____

**Clearance for dental procedures**

**Are you currently being treated for any medical conditions including recent surgeries or hospital visits? If so, please explain** ◯ Yes ◯ No

_____

_____

**Do you have any joint replacements?** ◯ Yes ◯ No

**If so, which joints and when were the surgeries?** _____

**Are you currently taking, or have you taken medications to control bone loss, for example Fosamax, Boniva, Actonel, Zometa, Aclasta, etc**
◯ Yes ◯ No

**Are you Pregnant?** ◯ Yes ◯ No

**Have you ever had any of the following heart conditions?**

- ☐ Artificial Heart Valve
- ☐ Congenital heart disease
- ☐ I have not had any of the above conditions
- ☐ Heart Infection (endocarditis)
- ☐ Heart transplant with irregularities/disease in the heart valves

**Allergic reactions and sensitivities**

**Please indicate which products cause allergic reaction or sensitivity**

- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Latex
- ☐ Other _____
- ☐ Erythromycin
- ☐ Aspirin or NSAIDS
- ☐ Foods/Flavoring
- ☐ I am not aware of any allergies or sensitivities
- ☐ Codeine
- ☐ Local Anesthetics
- ☐ Seasonal Allergies

**Other Allergy:** _____

**Current medications and supplements**

**Please list all current medications, including over the counter, prescription and supplements.**

_____

_____

_____

**Medical History**

**Do you currently have, or have you had in the past, any of the following conditions?**

- ☐ High Blood Pressure
- ☐ Heart attack or Angina (chest pain)
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Kidney disease/impaired kidney function
- ☐ Swollen Glands in Neck
- ☐ Pain in Jaw joint
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Other hormone or glandular problems
- ☐ Hepatitis
- ☐ Stomach ulcers
- ☐ Lupus
- ☐ AIDS or HIV
- ☐ Blood thinner medication
- ☐ Sexually Transmitted Disease
- ☐ Drug Addiction
- ☐ Damaged Heart Valves
- ☐ Pacemaker or other cardiac device
- ☐ Asthma
- ☐ Other Breathing Problems, eg COPD, Emphysema, ect.
- ☐ Fainting spells, Seizures or Epilepsy
- ☐ Frequent headaches
- ☐ Oral Cancer
- ☐ Sinus Problems
- ☐ Thyroid Disease
- ☐ Acid Reflux (GERD)
- ☐ Jaundice or Liver Disease
- ☐ Cancer/history of chemo or radiation treatment
- ☐ Multiple sclerosis
- ☐ Blood Disorder such as Anemia or hemophilia
- ☐ Arthritis
- ☐ Problems with Mental Health
- ☐ I have not had any of the above conditions.

**Information regarding affirmative responses above:**

_____

_____

**Do you currently or have you ever used tobacco products? (Including E-cigs)** ◯ Yes ◯ No

**If using currently, what type and how often?** _____

**How many alcohol-containing drinks do you consume a week?** _____

**Do you use recreational drugs?** ◯ Yes ◯ No

**If so, please list type and frequency.** _____

**What would you like to change about your smile?**

_____

_____

signature

Signature _____ **Date** _____

**Response Date:** ____/____/_____