Poudre Valley Family Dental

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

Have you visited a hospital, emergency room, or surgery center for any health condition or procedure in the last 6 months? *

Do you have any joint replacements? If so, which joints and when were they replaced? *

Are you required to take antibiotics prior to dental appointments?
If so, is it because of a heart condition or joint replacement?
Which antibiotic do you take? *

Are you currently taking, or have you taken, medications such as Fosamax, Boniva, Actonel, Zometa, Aclasta, etc, to control bone loss OR to prevent cancer metastasis? *

Please indicate if you have allergies or sensitivities to any of the following: *

- ☐ I am not aware of any allergies or sensitivities
- ☐ Penicillin
- ☐ Erythromycin
- ☐ Sulfa drugs
- ☐ Latex
- ☐ Codeine
- ☐ Aspirin or NSAIDs
- ☐ Local Anesthetics
- ☐ Foods/Flavoring
- ☐ Other (please explain below)

Additional information regarding allergies and sensitivities: *

Please indicate if you have ever had any of the following heart conditions: *

- ☐ I have not had any of the conditions listed below
- ☐ Artificial heart valve
- ☐ Heart infection (endocarditis)
- ☐ Heart transplant with irregularities in the heart valves
- ☐ Congenital heart disease (heart abnormality present from birth)
- ☐ Heart Attack or chest pain (angina)
- ☐ Atrial Fibrillation
- ☐ Stroke or Transient Ischemic Attack (TIA)
- ☐ Pacemaker or other cardiac device

Additional information regarding heart conditions: *

Are you currently pregnant? * ◯ Yes ◯ No

Do you need any particular accomodation for dental treatment? *

Please indicate if you have had any of the following medical conditions in the past, or currently: *

- ☐ I have not had any of the conditions listed below
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Sleep apnea
- ☐ GERD (Acid reflux)
- ☐ Pain in jaw joint
- ☐ Sinus problems
- ☐ Frequent Headaches
- ☐ Blood thinner medications
- ☐ Stomach ulcers
- ☐ Cold sores
- ☐ Arthritis
- ☐ Fainting spells, siezures, epilepsy
- ☐ Drug addiction
- ☐ Hepatitis B or C
- ☐ Other conditions that we should be aware of
- ☐ Asthma
- ☐ Breathing problems (eg COPD, Emphysema, etc)
- ☐ Seasonal Allergies
- ☐ Anxiety/Depression
- ☐ Other problems with mental health
- ☐ Cancer/History of chemo or radiation Tx
- ☐ Oral cancer history
- ☐ Multiple Schlerosis
- ☐ Blood disorders (eg anemia or hemophilia)
- ☐ Autoimmune disorders (eg rheumatoid arthritis, Lupus)
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Tuberculosis
- ☐ HIV or AIDS

Additional information regarding conditions selected above: *

Please list all current medications, including over-the-counter medicines, prescriptions, and supplements. *

**Do you currently use products containing nicotine (tobacco, e-cigarettes, Zyn, On!, VELO, etc) or THC (marijuana)?
If so, which products and how frequently? ***

**Have you used nicotine or THC products in the past?
If so, when did you quit? ***

When was your last visit to a physician? *

Did your physician have any concerns about your blood pressure at that visit? *

Name and phone number for your physician: *

What would you like to change about your smile? *

☐ ***I acknowledges that the information provided in this form is accurate to the best of my knowledge. I understand that failure to provide accurate health information may result in complications from dental and dental hygiene procedures that can negatively affect my overall health.**

Signature_____ Date_____

Response Date: _____