FRONTIER VILLAGE DENTAL CARE

Cosmetic and Family Dentistry

PATIENT NAME_____
MEDICAL DR'S NAME_____
MEDICAL DR'S PHONE # _____
DATE OF LAST DR VISIT _____
EMERGENCY CONTACT _____
EMERGENCY CONTACT #_____

Please list medications and/or supplements you are currently taking, along with dosage:

_____
_____
_____
_____
_____
_____

Do you have, or have you ever had any of the following diseases or medical problems?

Cardiovascular System

HIGH / LOW BLOOD PRESSURE	YES	NO
CONGENITAL HEART DISEASE	YES	NO
MITRAL VALVE PROLAPSE	YES	NO
RHEUMATIC FEVER	YES	NO
HEART MURMURS	YES	NO
HEART SURGERY	YES	NO
STENTS	YES	NO
ARTIFICIAL VALVES	YES	NO
HEART ATTACK OR STROKE	YES	NO
DATE _____		
SHORTNESS OF BREATH	YES	NO
SWOLLEN ANKLES	YES	NO
PACEMAKER	YES	NO
ANGINA (CHEST PAIN)	YES	NO
BLOOD THINNERS	YES	NO
HAVE YOU EVER TAKEN PREMED	YES	NO
WHY? _____		

Respiratory System

ASTHMA	YES	NO
EMPHYSEMA	YES	NO
TUBERCULOSIS (TB)	YES	NO
CHRONIC BRONCHITIS	YES	NO
PERSISTANT COUGH/COLDS	YES	NO
SINUS TROUBLE	YES	NO

Digestive System

DIABETES TYPE I/ TYPE II	YES	NO
MONITOR BLOOD SUGAR DAILY	YES	NO
THYROID DISEASE	YES	NO
KIDNEY DISEASE/MALFUNCTION	YES	NO
LIVER DISEASE/JAUNDICE	YES	NO
HEPATITIS A / B / C	YES	NO
CHRONIC DIARRHEA/CONSTIPATION	YES	NO
STOMACH ULCERS	YES	NO
CHRONIC DRY MOUTH	YES	NO

Bone and Joints

ARTIFICIAL JOINT: KNEE HIP OTHER	YES	NO
DATE OF SURGERY :_____		
ARTHRITIS OR RHEUMATISM	YES	NO
OSTEOPOROSIS	YES	NO
BISPHOSPHONATE THERAPY	YES	NO

WHICH MEDICATIONS: Fosamax, Actonel, Boniva, Skelif, Didronel, Aredia or Zometa

Nervous System

EPILEPSY OR SEIZURES	YES	NO
DEPRESSION/EMOTIONAL PROBLEMS	YES	NO
FAINTING OR DIZZY SPELLS	YES	NO

Blood Disorders

ANEMIA/HEMOPHILIA	YES	NO
EXCESSIVE BLEEDING/BRUISING	YES	NO
AIDS/ HIV POSITIVE	YES	NO
BLOOD TRANSFUSION	YES	NO

Cancer

MALIGNANCY	YES	NO
WHICH TYPE _____		
CHEMOTHERAPY	YES	NO
RADIATION THERAPY	YES	NO
DRUG THERAPY	YES	NO

Other

GLAUCOMA / CATARACTS	YES	NO
CONTACT LENSES	YES	NO
HARD OF HEARING	YES	NO
TOBACCO USE	YES	NO
ALCOHOL USE	YES	NO
SEXUALLY TRANSMITTED DISEASE	YES	NO
EATING DISORDER	YES	NO

WOMEN: Are you currently?

PREGNANT DUE DATE _____	YES	NO
NURSING	YES	NO
BIRTH CONTROL PILLS	YES	NO
HORMONAL THERAPY	YES	NO

Are you allergic to any of the following:

PENICILLIN	YES	NO
CODEINE	YES	NO
SULFA DRUGS	YES	NO
LATEX	YES	NO
DENTAL ANESTHETIC	YES	NO

LIST OTHER ALLERGIES, INCLUDING FOODS _____

_____
_____

Please list any other medical condition(s), surgeries and / or serious illnesses that we should be aware of:

_____
_____
_____

The above information is accurate and complete, to the best of my knowledge. I will not hold any member of Frontier Village Dental Care responsible for any errors or omissions that I may have made in the completion of this form. It is my responsibility to inform the office of any changes in medical status and I further realize that undiagnosed medical conditions can adversely affect dental outcomes.

Patient Signature _____ Date _____