ZOHNI FAMILY DENTAL
Compassionate and quality dentistry

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MEDICAL AND DENTAL HISTORY

Patient Name _____ Date of Birth _____ Today's Date _____

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication(s) that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Do you need to premedicate for dental?	☐ Yes	☐ No	If Yes *
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If Yes *
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If Yes *
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If Yes *
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	☐ Yes	☐ No	If Yes *
Are you taking any blood thinners, including daily aspirin?	☐ Yes	☐ No	If Yes *
Do you use tobacco?	☐ Yes	☐ No	
Do you use recreational substances?	☐ Yes	☐ No	

* *If you need more space to answer any of these questions, please continue in the COMMENTS section on the next page of this form.*

WOMEN: Are You . . .

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Sulfa Drugs
☐ Metal	☐ Latex	☐ Acrylic
☐ Preservatives	☐ Codeine	☐ Local Anesthetics

☐ Other? If Yes

PLEASE Continue on the NEXT PAGE —

MEDICAL AND DENTAL HISTORY — Continued

Do you have, or have you had, any of the following?

AIDS / HIV Positive	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No
Hives or Rash	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No
Cold Sores / Fever Blisters	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Crohn's or IBS	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Hepatitis B or C	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Swelling of Limbs	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Heart Attack / Failure	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Parathyroid Disease	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No

Hemophilia	☐ Yes	☐ No
Recent Weight Loss	☐ Yes	☐ No
Renal Dialysis	☐ Yes	☐ No
Rheumatism	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No
Excessive Thirst	☐ Yes	☐ No
Fainting Spells / Dizziness	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No
Stomach / Intestinal Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Seasonal Allergies	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Pain in Jaw Joints	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Acid Reflux	☐ Yes	☐ No
Radiation Treatments	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis / Gout	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No
Hypoglycemia	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumors or Growths	☐ Yes	☐ No
Heart Trouble / Disease	☐ Yes	☐ No
Sexually Transmitted Disease	☐ Yes	☐ No

If you answered Yes to any of the above, please explain:

Have you ever had any serious illness not listed? ☐ Yes ☐ No If Yes

COMMENTS:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Guardian: Date:

X _____ _____