Zoe Dental Medical History

Patient Name: Birth Date: Date Created:

Are you under a physician's care?	◯ Yes ◯ No	If yes
Have you been hospitalized within the past 5 years?	◯ Yes ◯ No	If yes
Are you taking any prescription or over the counter medicine(s)? Please list all below, including vitamins, natural	◯ Yes ◯ No	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes
Are you taking or scheduled to begin taking bone density medications or bisphosphonates such as Fosamax, Boniva,	◯ Yes ◯ No	If yes
Do you snore?	◯ Yes ◯ No	If yes
Do you use a CPAP?	◯ Yes ◯ No	

Do you take any type of blood thinner?

Aspirin	◯ Yes ◯ No	Fish Oil	◯ Yes ◯ No	Ginko Biloba	◯ Yes ◯ No	Vitamin E	◯ Yes ◯ No
Warfarin/ Coumadin	◯ Yes ◯ No	Plavix	◯ Yes ◯ No	Xarelto	◯ Yes ◯ No	Other	◯ Yes ◯ No

Premedication

Do you have or have had any of the following:

Artificial (Prosthetic) Heart	◯ Yes ◯ No	Previous Infective Endocarditis	◯ Yes ◯ No	Damaged Valves in Heart Transplant	◯ Yes ◯ No	Congenital Heart Disease	◯ Yes ◯ No
Total Knee Replacement	◯ Yes ◯ No	Total Hip Replacement	◯ Yes ◯ No	Total Elbow Replacement	◯ Yes ◯ No	Total Finger replacement	◯ Yes ◯ No
Any Organ Transplant	◯ Yes ◯ No						

List dates and any complications associated with the procedure:

Women:

Are you you currently:

Pregnant	◯ Yes ◯ No	Trying to Get Pregnant	◯ Yes ◯ No	Nursing	◯ Yes ◯ No	Taking Oral Contraceptives	◯ Yes ◯ No
Taking Hormone Replacements	◯ Yes ◯ No						

Are you allergic to or have you had a reaction to any of the following:

Aspirin	◯ Yes ◯ No	Penicillin	◯ Yes ◯ No	Codeine	◯ Yes ◯ No	Acrylic	◯ Yes ◯ No
Latex	◯ Yes ◯ No	Sulfa	◯ Yes ◯ No	Local Anesthetics	◯ Yes ◯ No	Metal	◯ Yes ◯ No
Mint	◯ Yes ◯ No	Essential Oils	◯ Yes ◯ No	Other	◯ Yes ◯ No	Adhesives	◯ Yes ◯ No

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

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Venereal Disease	◯ Yes ◯ No	Alzheimer's, Dementia or Memory loss	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Heart Attack/ Failure	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Hepatitis, Jaundice or Liver Disease	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Arthritis, Rheumatism	◯ Yes ◯ No	Eating Disorder	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No
Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No
Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No
Tobacco User	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Mental Health Disorder	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Sjogren's Syndrome	◯ Yes ◯ No
Sleep Apnea	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No
Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Severe Headaches/ Migraines	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No
Sinus Trouble	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No
Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No						

Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes

Office Use Only: Values and Barriers

Cosmetic	◯ Yes ◯ No	Function	◯ Yes ◯ No	Longevity	◯ Yes ◯ No	Comfort	◯ Yes ◯ No
Time	◯ Yes ◯ No	Trust	◯ Yes ◯ No	Budget	◯ Yes ◯ No	Fear	◯ Yes ◯ No

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, Parent or Guardian:

X Date:_____