Medical History

ZOMA DENTAL
FAMILY AND COSMETIC DENTISTRY

Patient Name: **Birth Date:** **Date Created:**

Question	Yes	No	If yes
Are you under Medical Treatment now? If yes, please explain:	Yes	No	If yes
Have you ever been hospitalized? If yes, please explain:	Yes	No	If yes
Are you taking any medications, pills, or drugs? Please list drugs:	Yes	No	If yes
Do you use alcohol?	Yes	No	If yes
Are you wearing Contact Lenses?	Yes	No	If yes
Do you use Tobacco?	Yes	No	If yes
Do you use controlled substances? If yes, please explain:	Yes	No	If yes

Women: Are you...

- Pregnant or Trying to get pregnant?
- Taking oral contraceptives?
- Nursing?

Are you allergic to any of the following?

- Aspirin
- Penicilin
- Codeine
- Local Anesthetics
- Acrylic
- Metal
- Latex
- Sulfa Drugs

Other? If yes, please explain: Yes No If yes

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

Condition	Yes	No
AIDS / HIV Positive	Yes	No
Anaphylaxis	Yes	No
Angina	Yes	No
Artificial Heart Valve	Yes	No
Asthma	Yes	No
Blood Transfusion	Yes	No
Bruise Easity	Yes	No
Chemotherapy	Yes	No
Cold Sores / Fever Blisters	Yes	No
Convulsions	Yes	No
Diabetes	Yes	No
Easily Winded	Yes	No
Epilepsy or Seizures	Yes	No
Excessive Thirst	Yes	No
Frequent Cough	Yes	No
Genital Herpes	Yes	No
Hay Fever	Yes	No
Heart Murmur	Yes	No
Heart Trouble / Disease	Yes	No
Hemophilia	Yes	No
Herpes	Yes	No
High Cholesterol	Yes	No
Hypoglycemia	Yes	No
Kidney Problems	Yes	No

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

Condition	Yes	No
Liver Disease	Yes	No
Lung Disease	Yes	No
Osteoporosis	Yes	No
Parathyroid Disease	Yes	No
Radiation Therapy	Yes	No
Renal Dialysis	Yes	No
Rheumatism	Yes	No
Shingles	Yes	No
Sinus Trouble	Yes	No
Stomach / Intestinal Disease	Yes	No
Swelling of Limbs	Yes	No
Tonsillitis	Yes	No
Tumors / Growth	Yes	No
Venereal Disease	Yes	No
Alzheimer's Disease	Yes	No
Anemia	Yes	No
Arthritis / Gout	Yes	No
Artificial Joint	Yes	No
Blood Disease	Yes	No
Breathing Problems	Yes	No
Cancer	Yes	No
Chest Pains	Yes	No
Congenital Heart Disorder	Yes	No
Cortisone Medicine	Yes	No

ZOMA DENTAL

FAMILY AND COSMETIC DENTISTRY

Medical History

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

Condition	Yes	No
Drug Addiction	Yes	No
Emphysema	Yes	No
Excessive Bleeding	Yes	No
Fainting Spells / Dizziness	Yes	No
Frequent Diarrhea	Yes	No
Glaucoma	Yes	No
Heart Attack / Failure	Yes	No
Heart Pacemaker	Yes	No
Hepatitis A	Yes	No
Hepatitis B or C	Yes	No
High Blood Pressure	Yes	No
Hives or Rash	Yes	No
Irregular Heartbeat	Yes	No
Leukemia	Yes	No

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

Condition	Yes	No
Low Blood Pressure	Yes	No
Mitral Valve Prolapse	Yes	No
Pain in Jaw Joints	Yes	No
Psychiatric Care	Yes	No
Recent Weight Loss	Yes	No
Rheumatic Fever	Yes	No
Scarlet Fever	Yes	No
Sickle Cell Disease	Yes	No
Spina Bifida	Yes	No
Stroke	Yes	No
Thyroid Disease	Yes	No
Tuberculosis	Yes	No
Ulcers	Yes	No

Dental History

Question	Yes	No
Do your gums bleed while brushing or flossing?	Yes	No
Are your teeth sensitive to sweet or sour items?	Yes	No
Do you have sores or lumps in or near your mouth?	Yes	No
Do you snore or have been told you snore?	Yes	No
Have you had any head, neck or jaw injury?	Yes	No
Have you ever had any difficulties with extracting a tooth?	Yes	No
Have you ever experienced prolonged bleeding?	Yes	No
Do you have frequent headaches?	Yes	No

Have you experienced pain in any of the following areas:

Face Mouth Ears Joints

Difficulty in chewing? Yes No

If yes, what?

Dental History

Question	Yes	No
Are your teeth sensitive to hot or cold?	Yes	No
Do you feel pain to any of your teeth?	Yes	No
History of Periodontal Therapy?	Yes	No
Have you ever received oral hygiene instructions?	Yes	No
Do you bite your lips or cheeks frequently?	Yes	No
Have you had orthodontic treatment?	Yes	No
Do you wear partials or dentures?	Yes	No
Do you clench or grind your teeth?	Yes	No
Do you have clicking or popping in your jaw?	Yes	No
Do you have difficulty in opening or closing your jaw?	Yes	No
Is there anything you would like to change about your smile?	Yes	No

If yes, what?

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 ______________________