DAG ZAPATERO, D.D.S.

General | Cosmetic | Restorative | Implant | TMJ | Sleep | Geriatric Dental Care

MEDICAL HISTORY - UPDATE

Name: _____

General Health (please circle): Excellent Good Fair Poor Physician: _____

Physician's address: _____ Phone: _____

Are you allergic to any medication? Yes NoIf yes, list the medication: _____

Are you allergic to Latex? Yes No Are you taking any medications now? Yes No

If yes, please list the medications and medical condition for which they are being taken: _____

_____

Have you ever had any of the following? Please circle any condition that applies to you:

Heart Disease	Anemia	Mitral Valve Prolapse	Hepatitis
Rheumatic Fever	Arthritis	Heart Murmur	Glaucoma
Night Sweats	Lymph Node Enlargement	Allergies	Stroke
High Blood Pressure	(swollen glands)	Jaundice	Fainting Spells
Ulcers	Migraine Headaches	Drastic Weight Loss	Cancer
Tuberculosis or Lung Cancer	HIV/AIDS	Asthma	Congenital Heart Lesions
Diabetes	Prolonged Bleeding	Hay Fever	Joint replacement
Epilepsy	Excessive Urination	Sinus Trouble	Date _____
	and/or Thirst		

Female patients: Are you pregnant? _____ Number# of months: _____ Nursing? Yes No Taking birth control? Yes No

Do you smoke, use tobacco, alcohol or drugs? Yes No If yes, list the type and how often:

If you have circled any of the above conditions, please explain or if you have or have had any disease, condition or problem not listed above please explain:

_____

Please add anything you feel is important for the staff and doctor to know about you. _____

_____

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner, By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matter related to this form. I have answered all questions to the best of my knowledge. Should further medical information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you.

Patient Signature: _____ Date: _____

If patient is UNDER 18 YEARS OLD, parent or legal guardian MUST sign above. If you were assisted with this form, please enter the name of the person who assisted you: _____ Relationship to Patient: _____