DAG ZAPATERO, D.D.S., M.A.G.D.

General | Cosmetic | Restorative | Implant | Geriatric Dental Care

MEDICAL & DENTAL HISTORY

Name: _____ Date: _____

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

Physician's Phone: (_____) _____ Last Physical Exam: _____

Allergic to any medications? ☐ Yes ☐ No If yes, list: _____

Allergic to Latex? ☐ Yes ☐ No Other allergies (food, materials, etc.): _____

CURRENT MEDICATIONS: Are you taking any medications, vitamins, or supplements? ☐ Yes ☐ No

Please list medications and the condition they are taken for: _____

_____

FOR WOMEN: Pregnant? ☐ Yes ☐ No # of months: ____ Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Please check all that apply)

☐ Heart Disease / Heart Attack	☐ Asthma / Breathing Problems	☐ Bleeding Problems / Hemophilia
☐ High Blood Pressure	☐ Sleep Apnea / CPAP	☐ Blood Thinners (Coumadin, etc.)
☐ Heart Murmur / Valve Problems	☐ Tuberculosis / Lung Disease	☐ Anemia
☐ Artificial Heart Valve / Stent	☐ Hepatitis (A, B, or C)	☐ Arthritis / Joint Replacement
☐ Stroke / TIA	☐ HIV / AIDS	☐ Osteoporosis / Bisphosphonates
☐ Pacemaker / Defibrillator	☐ Kidney Disease	☐ Epilepsy / Seizures
☐ Diabetes (Type 1 or 2)	☐ Liver Disease / Jaundice	☐ Fainting / Dizziness
☐ Excessive Thirst / Urination	☐ Cancer / Radiation / Chemo	☐ Glaucoma

If you checked any of the above, or have any other condition not listed, please explain:

_____

SOCIAL HISTORY : Do you smoke, vape, use tobacco, alcohol, or recreational drugs? ☐ Yes ☐ No

If yes, please describe type and frequency: _____

A FEW QUESTIONS TO HELP US GET TO KNOW YOU

1. What are your main goals or concerns about your teeth or smile? _____
2. Is there anything that makes dental visits stressful or difficult for you? _____
3. What do you hope to achieve from today's visit? _____

DENTAL HISTORY:

Are you currently having any dental pain or discomfort? ☐ Yes ☐ No If yes: _____

Last dental visit: _____ Last cleaning: _____ Last full set of X-rays: _____

Anything else you would like the doctor to know? _____

ACKNOWLEDGEMENT: I understand the above information is necessary to provide me with safe and efficient dental care. I have answered all questions to the best of my knowledge. I grant permission for this office to contact my physician if additional medical information is needed.

_____ _____

Patient (or Parent/Guardian if under 18) Signature Date

If assisted with this form, name of person who helped: _____ Relationship: _____