Medical History – CONFIDENTIAL ❖ ❖ ❖ ❖ ❖ ❖ Dr. Mark S. Zurawel, DDS

Patient Name: _____ Date: _____

Current Physician Name and Phone #: _____

Hospitalizations: _____

Medications (current or within past 6 months) :_____

_____

Do you require pre-medication? If yes, please list drug and reason: _____

Do you have allergies/adverse reactions to: Aspirin Codeine Penicillin Erythromycin Shellfish Latex Sulfa Nitrous Oxide Barbiturates Local Anesthetic Lidocaine Other: _____

Do you currently have, or had in the past, any of the following (Please circle all that apply)**:**

- ☐ Skin Conditions (Rashes, infections, allergies, etc): _____
- ☐ Joint or muscle soreness, arthritis, joint replacement: _____
- ☐ Blurred Vision, Glaucoma, Cataracts
- ☐ Nosebleeds, hearing loss, sinus infection, seasonal allergies, Vertigo
- ☐ Asthma, Bronchitis, Chronic Cough, Emphysema, Pneumonia, Tuberculosis, Sleep Apnea
- ☐ Heart attack, Heart disease, Angina, Murmur, High Blood Pressure, Low Blood Pressure, Pacemaker, Prosthetic valves, Rheumatic/scarlet fever, swelling of ankles, High Cholesterol
- ☐ Jaundice, Hepatitis, Other Liver Disease, Gastric reflux, Stomach Ulcers
- ☐ Urinary system problems, kidney disease, kidney stones, Prostate disease, STDs, HPV, Herpes
- ☐ Pregnancy, Hormone Therapy, Diabetes, Thyroid disorder
- ☐ AIDS/HIV, Hemophilia, Anemia, Sickle Cell Anemia, Clotting Disorder, Aspirin Therapy/Anti-Coagulants
- ☐ Headaches, Seizures/Epilepsy, Paralysis, Stroke, Other Neurological Disorders
- ☐ ADHD, Anxiety, Depression, Other Mental Health Disorders
- ☐ Organ Transplant: _____
- ☐ Cancer – Location, History of Radiation and/or Chemo: _____
  _____

Substance Use – Please list Current/Historical Use of the Following with Type, Amount & Frequency. For Example: 1 pack of cigarettes daily for 5 years. Use of these substances can put you at higher risk for oral cancer and other conditions. It can also be crucial in determining what medications/anesthetics we may use/prescribe as part of your treatment. Please be honest and rest assured that this and any other information you provide to us will remain confidential. Our only concern is your health & safety.

Tobacco: _____
Alcohol: _____
Recreational Drugs: _____

Dental History: How long since your last dental exam? _____ Dental Xrays? _____

Any difficulties/apprehensiveness with dental treatment?_____

Do you regularly use dental floss/other items to clean between your teeth? _____

Have you noticed your gums bleeding when you brush or floss? _____

Are any of your teeth sensitive to hot/cold/sweets/pressure? _____

Are you aware or any clenching or grinding? Any jaw pain? _____

Any sores or lumps in or near your mouth? _____