# Medical History Form

Page 1

Page 1


Lynelle J. Zabel, D.D.S., P.C.
Highlands Ranch Dental Care | 9137 Ridgeline Blvd Ste 150 - Highlands Ranch, CO 80129
(303)470-0017
www.highlandsranchdentalcare.com | appointments@highlandsranchdentalcare.com

## Medical History

Patient's Last Name *

Patient's First Name *

MI

Preferred Name

Name of your Physician

Phone Number (___) ___-____

Preferred Pharmacy

Phone Number (___) ___-____

**Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.**

- [ ] ADD/ADHD
- [ ] AFIB
- [ ] Acid Reflux
- [ ] Anemia
- [ ] Arrythmia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Artificial heart valve
- [ ] Asthma
- [ ] Autoimmune disease
- [ ] Back problems
- [ ] Blood Disorder
- [ ] Blood Thinners
- [ ] Blood Transfusion
- [ ] Dementia
- [ ] Dental Anxiety
- [ ] Depression
- [ ] Diabetes
- [ ] Dogs
- [ ] Endocarditis
- [ ] Epilepsy
- [ ] Fainting
- [ ] Fluoride
- [ ] Gastrix Reflux
- [ ] Glaucoma
- [ ] HIV/AIDS
- [ ] HPV
- [ ] Headaches
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Hyper-thyroid
- [ ] Hypo-thyroid
- [ ] Kidney Disease
- [ ] Legally Blind
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Migraines
- [ ] Mitral Valve Repair
- [ ] Organ Transplant
- [ ] Osteopenia
- [ ] Osteoporosis
- [ ] Pacemaker
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Restricted Diet
- [ ] Rheumatoid Arthritis
- [ ] Seizures
- [ ] Septocaine
- [ ] Shortness of Breath
- [ ] Sinus Problems
- [ ] Sleep Apnea
- [ ] Smoker/Tobacco use
- [ ] Stroke
- [ ] TMJ Issues
- [ ] Thyroid Problems

- [ ] CO-Pulmonory Disease
- [ ] Cancer
- [ ] Cataracts
- [ ] Celiacs disease
- [ ] Copper
- [ ] Crohn's disease
- [ ] DVT
- [ ] Hear Murmur
- [ ] Hearing loss
- [ ] Heart Attack
- [ ] Heart Disease/Murmur
- [ ] Heart Stent
- [ ] Heart Valve Replace
- [ ] Hepatitis
- [ ] Herpes
- [ ] Painful swollen Join
- [ ] Parkinson's Disease
- [ ] Prob w/Immune system
- [ ] Pulmonary Embolism
- [ ] Tuberculosis
- [ ] Tumor
- [ ] Ulcers
- [ ] Vision Loss
- [ ] Inborn heart defect
- [ ] Mitral valve prolapse
- [ ] Other

**Please explain/clarify any conditions or alerts selected above:**

Page 2

**Are you allergic or have you had a reaction to:**

- [ ] Alcohol
- [ ] Aspirin
- [ ] Codeine or other
- [ ] Iodine
- [ ] Local anesthetics
- [ ] Barbiturrates, sedatives, or sleeping pills
- [ ] Penicillin
- [ ] Latex
- [ ] Narcotics
- [ ] Other antibiotics
- [ ] Dogs
- [ ] Sulfa drugs
- [ ] Red dye
- [ ] Acrylic
- [ ] Silver
- [ ] Other

Allergies not listed

Type of reaction?

Female patients: Are you pregnant?

○ Yes ○ No

Are you nursing?

○ Yes ○ No

Have you had joint replacement surgery or orthopedic surgery with plates, pins, or screws? *

○ Yes ○ No

Do you take antibiotic premedication for the surgery listed above? *

○ Yes ○ No

Do you have a cardiac pacemaker? *

○ Yes ○ No

Do you have an inborn heart defect? *

○ Yes ○ No

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin, vitamins, etc.? *

○ Yes ○ No

Have you ever had any growth/tumor/or cancer? *

○ Yes ○ No

Page 3

Do you have any blood disorder such as anemia? *

Yes No

Do you take Bisphosphonates (bone density drugs)? *

Yes No

Have you ever had abnormal bleeding? *

Yes No

Have you been diagnosed with sleep apnea? *

Yes No

Have you been told you stop breathing or snore when you sleep? *

Yes No

Do you smoke or use tobacco products? *

Yes No

Describe any current medical treatment, impending surgery, or other treatment that has not been listed below:

☐ **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.** *

## *THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY*

**Please review and update the following information if needed. Thank you.**

Chart#

FOR OFFICE USE ONLY

Patient's Last Name *

Patient's First Name *

MI

Preferred Name

Title

Mr/Ms/Mrs/etc

Gender

- Male
- Female

Family Status

- Married
- Single
- Child
- Other

Birth Date

MM/dd/yyyy

Prev. Visit

Email Address

Home Phone

(___) ___-____

Mobile Phone

(___) ___-____

Work Phone

(___) ___-____

Extension

Best time to call

Address *

Street Address, City, State, Zip-Code

Response Date

10/08/2025

Patient Signature *