Zora & Hanko
Doctor of Dental Medicine
950 Francis Place, Suite 206 | Clayton, MO 63105 | (314) 721-1660 office | (314) 496-4488 cell
drzhanko@gmail.com | www.hankodental.com

Medical Information

Please mark (X) to indicate if you have or have had any of the following diseases or problems.

- ☐ Angina
- ☐ Congestive heart failure
- ☐ Damaged heart valves
- ☐ Artificial heart valves
- ☐ Previous infective endocarditis
- ☐ Congenital heart defects
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Rheumatic heart disease
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Stroke
- ☐ Blood transfusion
- ☐ Anemia
- ☐ Hemophilia
- ☐ AIDS/HIV
- ☐ Excessive Bleeding
- ☐ Arthritis
- ☐ Autoimmune disease
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Eating disorder
- ☐ Gastrointestinal disease
- ☐ GE reflux (GERD)
- ☐ Heartburn
- ☐ Ulcers
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Crohn's disease
- ☐ Celiac disease
- ☐ Liver disease
- ☐ Epilepsy
- ☐ Fainting spells, seizures
- ☐ Glaucoma
- ☐ Sleep disorder
- ☐ Do you snore?
- ☐ Mental disorders
- ☐ Recurrent infections
- ☐ Kidney problems
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Persistent swollen glands in the neck
- ☐ Severe headaches, migraines
- ☐ Sexually transmitted disease
- ☐ Chemical dependency
- ☐ Tobacco habit
- ☐ Snuff or chewing tobacco
- ☐ Neurological disorders
- ☐ Birth control pills
- ☐ Hormone Replacement

☐ Have you had an orthopedic total joint replacement (hip, knee, elbow, finger, shoulder)? If yes, provide date:_____

☐ Has your physician advised you to pre-medicate with an antibiotic prior to dental work? If yes, why:_____

Name of antibiotic and recommended dosage and regimen:_____

Please provide name and phone number of the prescribing physician:_____

☐ Are you taking or scheduled to begin taking an antiresorptive agent (Fosamax*, Actonel*, Atlevia*, Boniva*, Reclasts*, Prolia* for osteoporosis or Paget's disease?

☐ Are you taking aspirin or other blood thinners?

☐ Do you have sleep Apnea?If yes, do you use a CPAP (continuous positive airway pressure) device?

☐ Do you have any disease, condition, or problem not listed above that you think I should know about?

If yes, please explain:_____

NOTES:_____

_____

Medications

List medication(s) you are currently taking including any over the counter medication, vitamins, and/or herbal preparations:

_____

_____

_____

_____

_____

Pharmacy Name: _____

Pharmacy Phone: _____

Allergies

- ☐ Penicillin or other antibiotics
- ☐ Barbiturates
- ☐ Sedatives or sleeping pills
- ☐ Sulfa drugs
- ☐ Codeine or other narcotics
- ☐ Metals
- ☐ Latex
- ☐ Hay fever or seasonal allergies
- ☐ _____
- ☐ _____

Signature

I certify that I have read and understand the above and that the information given on the Dental and Medical form is accurate.

_____ (Printed Name of Patient, Parent, or Guardian)

_____ (Signature of Patient, Parent, or Guardian)

_____ Date