Southern Dental
Cosmetic and Family Dentistry

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Date _____

MEDICAL HISTORY

First Name: _____ Middle Name: _____ Last Name: _____

Preferred Name: _____

Name and phone number of your physician:

_____

_____

Name and phone number of your preferred pharmacy:

_____

_____

_____

Please list all current medications (prescriptions and non-prescriptions)

_____

_____

_____

Indicate which of the following conditions are active or current.
By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- Allergies ☐
- Antibiotic Allergy ☐
- Asthma ☐
- Chemical Dependency ☐
- Diabetes ☐
- Erythromycin Allergy ☐
- Hay Fever ☐
- Heart Murmur ☐
- Kidney Disease ☐
- M.V.P. ☐
- Novocaine ☐
- Penicillin Allergy ☐
- Radiation Treatment ☐
- See Med History ☐
- Stomach Problems ☐
- Thyroid Problems ☐
- Alzheimer's ☐
- Art. Heart Valve ☐
- Blood Thinner ☐
- Codeine Allergy ☐
- Dialysis ☐
- Excessive Bleeding ☐
- Head Injuries ☐
- Hepatitis ☐
- Latex allergies ☐
- Mental Disorders ☐
- Osteoporosis/penia ☐
- Pre-Medicate ☐
- Respiratory Problems ☐
- SEIZURES ☐
- Stroke ☐
- Tuberculosis ☐
- Anemia ☐
- Arthritis ☐
- Blood Transfusion ☐
- COPD ☐
- Dizziness ☐
- Fainting ☐
- Heart Attack ☐
- High Blood Pressure ☐
- Liver Disease ☐
- Metal allergy ☐
- Other ☐
- Pregnancy ☐
- Rheumatic Fever ☐
- Sinus Problems ☐
- Sulfa Allergy ☐
- Tumors ☐
- Angina ☐
- Artificial joint ☐
- Cancer ☐
- Crohn's Disease ☐
- Epilepsy ☐
- Glaucoma ☐
- Heart Disease ☐
- HIV ☐
- Lupus ☐
- Nervous ☐
- Pacemaker ☐
- Psychiatric TX ☐
- Rheumatoid Arthritis ☐
- Spleen removed ☐
- Tetracycline Allergy ☐
- Ulcers ☐
- Joint Replacements ☐

- Recent hospitalization ☐
- FEMALE: Currently pregnant/possibly pregnant ☐
- FEMALE: Taking birth control pills ☐
- Alcohol Use ☐
- Tobacco/Vape Use ☐
- FEMALE: Nursing ☐

If any conditions or alerts selected above need further clarification, please describe:

_____

_____

Any medical conditions not listed above? If yes, please explain:? ☐ Yes ☐ No

_____

_____