Offices of Heather Bond Southard, DDS

Medical Information:

Name: ___________________________________ Date: _______________________

- Have you ever had an operation or serious illness? _____YES _____NO

If yes, please explain ____

- Have you ever had an allergic or adverse reaction to any drug or medications? _____YES _____NO

If yes, please explain ____

- Do you smoke? _____YES _____NO if yes, how much? ___________________________
- Do you drink? _____YES _____No if yes, how much? ______________________________

Is there anything about your general health that we should know about?
____

Allergens

☐ No known allergens	☐ Iodine	☐ Plastic
☐ Antibiotics	☐ Latex	☐ Sedatives
☐ Aspirin	☐ Local anesthetics	☐ Sleeping pills
☐ Barbiturates	☐ Metals	☐ Sulfa drugs
☐ Codeine	☐ Penicillin	

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?
If YES, please circle

Heart Murmur
Congenital Heart Lesions
Angina Pectoris
Heart Pacemaker
Stroke
Anemia
Hepatitis
Asthma
Chronic Cough
Tumors
Liver or Kidney Trouble
Chemotherapy
Sinus Trouble
Bruise Easily

Fainting or Dizzy Spells
AIDS/HIV
Thyroid Trouble
Rheumatic Fever
Heart Disease
Heart Attack
Artificial Heart Valves
Heart Surgery
High Blood Pressure
Low Blood Pressure
Diabetes
Emphysema
Tuberculosis
Arthritis

Cold Sores
Pain in Jaw Joint
Radiation Therapy
Mouth Ulcers
Epilepsy
Seizures
Mononucleosis
Stomach Ulcers
Pregnancy
Breastfeeding

Do you take blood thinners? YES NO

Have you ever been told you need a pre med before dental work? YES NO

Have you ever taken Bisphosphonates (bone builders)? YES NO

____ ______________________
Signature of patient/parent of guardian Date