SOUTHERNHEIGHTS DENTAL GROUP

Medical/Dental History

Last Name: First Name: Birthdate:

Name of Medical Doctor: City/State:

Emergency Contact Phone Relationship

List all medications that you are now taking:

List any major surgeries:

Are you allergic to any of the following? Please add others.

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease	☐	☐	Dental Anxiety
☐	☐	Bleeding Problems	☐	☐	Liver Disease	☐	☐	High Cholesterol
☐	☐	Cancer	☐	☐	Pregnancy	☐	☐	Depression
☐	☐	Diabetes	☐	☐	Mental illness	☐	☐	HIV/AIDS
☐	☐	Seizures/Epilepsy	☐	☐	Sinus Trouble	☐	☐	Hepatitis B/A/C
☐	☐	Autism Spectrum	☐	☐	Stroke	☐	☐	Tuberculosis TB
☐	☐	High Blood Pressure	☐	☐	Acid Reflux	☐	☐	Migraines/Frequent Headaches
☐	☐	Joint Replacement	☐	☐	Dry Mouth			
☐	☐	Do you have heart trouble? If yes:						

Sleep History

Do you snore or have been told you snore?

Do you have a CPAP? Do you wear it? Do have an Oral Sleep Appliance? Do you wear it?

Do you wake up feeling refreshed? Do you feel sleepy during the day?

Other

Tobacco use? If so, what kind and how much?

Unusual reaction to dental injections?

Reason for today's visit?

Are you in pain?

How often do you brush? Floss?

Are you happy with your smile?

Do you have a morning headache, grind, or clench your teeth?

Any other medical conditions not listed?

Have you been advised by your physician to take pre-medications prior to dental treatment? YES ☐ NO ☐

Reason?

Signature: Date: