Steven M. SOUTHWOOD
Jerry M. Brian J. PAUL POPE
FAMILY DENTISTRY
www.southwoodsmiles.com

Patient Information

Full Name: _____ Nick Name: _____ SS#: _____
Parents' Names (if child): _____ Address: _____
Phone Number(s): _____(Home) City: _____ State: _____
_____(Cell) _____(Work) Zip: _____ DOB: _____
E-mail Address: _____ Marital Status: ☐ Single ☐ Married Gender: ☐ M ☐ F
How did you hear about our office? _____ School (if applicable): _____

Medical History

Physician Name: _____ Phone #: _____ Most Recent Physical Exam: _____

Have you ever had the following:	Y	N
1. hospitalization for illness or injury _____	☐	☐
2. allergic reaction to: _____		
• aspirin, ibuprofen, acetaminophen ____	☐	☐
• penicillin _____	☐	☐
• erythromycin _____	☐	☐
• tetracycline _____	☐	☐
• codeine _____	☐	☐
• local anesthetic _____	☐	☐
• fluoride _____	☐	☐
• metals (gold, stainless steel) _____	☐	☐
• latex _____	☐	☐
• any other medications: _____	☐	☐
3. heart problems _____	☐	☐
4. heart murmur _____	☐	☐
5. rheumatic fever _____	☐	☐
6. scarlet fever _____	☐	☐
7. high blood pressure _____	☐	☐
8. low blood pressure _____	☐	☐
9. stroke _____	☐	☐
10. artificial prosthesis (joints, heart valves) ____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut _____	☐	☐
13. emphysema _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleeping problems _____	☐	☐
17. kidney disease _____	☐	☐
18. thyroid or parathyroid disease _____	☐	☐
19. hormone deficiency _____	☐	☐
20. high cholesterol _____	☐	☐
21. diabetes (type) _____	☐	☐
22. stomach or duodenal ulcer _____	☐	☐
23. digestive disorders (i.e. gastric reflux) _____	☐	☐
24. arthritis _____	☐	☐
25. head or neck injuries _____	☐	☐
26. epilepsy (seizures) _____	☐	☐
27. neurologic problems _____	☐	☐
28. viral infections/cold sores _____	☐	☐
29. lumps or swelling in the mouth _____	☐	☐
30. hives, skin rash, hay fever _____	☐	☐
31. tumor, abnormal growth _____	☐	☐
32. radiation therapy _____	☐	☐
33. chemotherapy _____	☐	☐
34. HIV/AIDS _____	☐	☐
35. hepatitis (type) _____	☐	☐
36. smoke or use tobacco _____	☐	☐
37. alcohol/drug dependency _____	☐	☐
Are you:	☐	☐
38. taking medicine for osteoporosis/osteopenia _	☐	☐
39. often exhausted or fatigued _____	☐	☐
40. subject to frequent headaches _____	☐	☐
41. MALE - prostate disorders _____	☐	☐
42. FEMALE - taking birth control pills _____	☐	☐
43. FEMALE - pregnant or nursing _____	☐	☐
44. presently being treated for any other illness _	☐	☐
_____		

List any medications, supplements, and/or vitamins taken within the last two years

Medication/Dose	Purpose	Medication/Dose	Purpose

Office Use Only:

Date: _____ Initials: _____	Date: _____ Initials: _____	Date: _____ Initials: _____	Date: _____ Initials: _____
Comments: _____	Comments: _____	Comments: _____	Comments: _____