SOUTHERN ROOTS
PERIODONTICS AND DENTAL IMPLANT SPECIALISTS

Medical History

Last Name: _____ First Name: _____ Birthdate: _____
Name of Medical Doctor: _____ City/State: _____
Emergency Contact _____ Phone _____ Relationship _____
If under 18 please list approximate height and weight: _____

List all medications that you are now taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you allergic to any of the following? Mark all that apply:

- ☐ Anesthetic
- ☐ Aspirin
- ☐ Codeine
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa

Any other allergies? _____

Do you currently have or have you had any of the following medical conditions? Mark all that apply:

- ☐ Breathing disorder
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Thyroid Condition
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pregnancy
- ☐ Neurological Treatment
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Gastrointestinal Issues or Ulcers
- ☐ Rheumatic Fever
- ☐ Infectious Disease (Herpes, AIDS, etc.)

Any additional medical information, disease, condition, or problem not listed above?

_____

Unusual reaction to dental injections? _____
Female Patient: Are you pregnant or nursing? _____
Female Patient: Do you take birth control? _____
Have you ever taken any medications for osteoporosis, bone cancer, or post-menopausal bone loss? _____
If so, what medication? _____
Any significant operations or hospitilizations? _____
Do you use tobacco, niccotine products, or marijuana? If so, what kind and how much? _____
Have you ever used the above products in the past? If yes, when did you quit? _____

Sign Here

Date: 05/18/2023