SOUTHERN ROOTS
PERIODONTICS AND DENTAL IMPLANT SPECIALISTS

Medical History for New Patient

Last Name: _____ First Name: _____ Birthdate: _____
Name of Medical Doctor: _____ City/State: _____
Emergency Contact _____ Phone _____ Relationship _____

List all medications that you are now taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you allergic to any of the following?

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

Tobacco use? If so, what kind and how much? _____
Unusual reaction to dental injections? _____
Any other allergies? _____
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? _____
Any additional medical information, disease, condition, or problem not listed above?

Date: 07/26/2022