Phillip Roe, DDS, MS
Fixed Prosthodontics and Implant Surgery

MEDICAL HISTORY AND UPDATES

PATIENT NAME _____ **DATE** _____

MEDICAL HISTORY

Medical Doctor's name _____
Are you under a doctor's care now? Why? _____
Have you suffered any serious injury to your head or neck? _____
Have you been hospitalized during the past two years? Why? _____
Are you taking any medications, pills, or drugs? What? _____
Are you allergic to any medications or substances? What? _____
Are you on a special diet? _____
Women—Are you pregnant? How many months? _____
Are you currently taking or have you been on any medications containing bisphosphates?
Please ☑ mark the checkbox if you have, or have had, any of the following:
If you circle any of the conditions marked with an asterisk (*) you may require premedication for dental treatment

☐ High Blood Pressure	☐ Chest Pain	☐ Hay Fever	☐ Blood Transfusion	☐ Drug Addiction
☐ Low Blood Pressure	☐ Shortness of Breath	☐ Sinus trouble	☐ Chemotherapy	☐ Psychiatric Care
☐ Heart Trouble	☐ Swelling of feet/ankles	☐ Emphysema	☐ Arthritis	☐ Veneral Disease
☐ Heart Murmur*	☐ Fainting or Dizziness	☐ Frequent Cough	☐ Rheumatism	☐ AIDS
☐ Rheumatic Fever*	☐ Stroke	☐ Lung Disease	☐ Pain in Jaw Joints	☐ Hemophelia
☐ Congenital Heart Lesion	☐ Diabetes	☐ Tuberculosis	☐ Cortisone Medication	☐ Cold Sores
☐ Artificial Heart Valve*	☐ Excessive Thirst	☐ Liver Disease	☐ Glaucoma	☐ Sickle Cell Anemia
☐ Heart Surgery*	☐ Asthma	☐ Hepatitis A (infec.)	☐ Epilepsy or Seizures	☐ Fever Blisters
☐ Heart Pacemaker*	☐ Kidney Trouble	☐ Hepatitis B (serum)	☐ Thyroid Disease	☐ Bruise Easily
☐ Blood Disease	☐ Ulcers	☐ Anemia	☐ Parathyroid Disease	☐ Herpes
☐ Mitral Valve Prolapse*	☐ Allergies	☐ Scarlet Fever	☐ Cancer	☐ Gout
☐ Artificial Joints* e.g. Hip	☐ HIV Positive	☐ Hypoglycemia	☐ X-ray or Cobalt Treatment	☐ Osteoporosis

Have you ever had any other serious illness, not circled above? _____
Please describe _____
Do you wish to talk to the doctor privately about any problem? _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status, or if my medication changes, I shall inform the doctor and staff at the next appointment without fail.

PATIENT SIGNATURE: _____

REVIEWED BY DOCTOR: _____

MEDICAL HISTORY UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions	None	Patient Signature	Reviewed by

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