DR. KARL "TONY" ROSE
Periodontal & Implant Associates
OF GREATER WASHINGTON

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CHEVY CHASE, MD 20815

MEDICAL HISTORY UPDATE

We request this information so that your doctor is aware of your medical status and may render the most appropriate care. This information will remain strictly confidential.

Name:_____ Date: _____

Home Address:_____

City:_____ State:_____ Zip:_____ Home Phone: (_____)_____

Work Phone: (_____)_____ Email:_____

Occupation:_____ Cell Phone: (_____)_____

Pharmacy:_____ Phone: (_____)_____

Have there been any changes in your medical status in the last year? If so, please explain:_____

_____

If you are currently under the care of a physician, please explain:_____

_____

Physician's Name:_____ Phone: (_____)_____

Emergency Contact:_____ Phone: (_____)_____

Are you allergic to, or have you ever had a reaction to any of the following drugs? Check those that apply:

- ☐ Penicillin
- ☐ Demerol
- ☐ Carbocaine
- ☐ Iodine
- ☐ Erythromycin
- ☐ Codeine
- ☐ Vicodin
- ☐ Novocaine
- ☐ Latex
- ☐ Tylenol
- ☐ Epinephrine
- ☐ Xylocaine
- ☐ Percocet
- ☐ Barbiturates
- ☐ Aspirin
- ☐ Tetracycline
- ☐ Valium
- ☐ Sulfa
- ☐ Advil/Motrin
- ☐ Other: _____

Do you or have you had any of the following conditions? Check those that apply:

- ☐ HIGH BLOOD PRESSURE
- ☐ GLAUCOMA
- ☐ CANCER, TUMOR OR GROWTH
- ☐ STROKE
- ☐ LIVER OR KIDNEY DISEASE
- ☐ IMPLANTS/ARTIFICIAL JOINTS
- ☐ ASTHMA/LUNG DISEASE
- ☐ ORGAN TRANSPLANT
- ☐ ARTHRITIS
- ☐ ORAL ULCERS/FEVER BLISTERS
- ☐ THYROID PROBLEMS
- ☐ HEART MURMUR
- ☐ RHEUMATIC FEVER
- ☐ CHEMOTHERAPY
- ☐ BLOOD DISORDERS/ANEMIA
- ☐ HEPATITIS
- ☐ TUBERCULOSIS
- ☐ PSYCHIATRIC THERAPY
- ☐ SINUS PROBLEMS
- ☐ AIDS/HIV
- ☐ HEART DISEASE
- ☐ PROLAPSED VALVE
- ☐ RADIATION TREATMENT
- ☐ BLEEDING PROBLEMS
- ☐ DIABETES
- ☐ EPILEPSY
- ☐ ALCOHOL/DRUG ABUSE
- ☐ WEIGHT REDUCTION VIA REDUX/FEN PHEN

Patient Signature:_____ Date:_____

Doctor's Signature:_____ Date:_____

Print Form