Medical History Update

Patient Name: ______________________________________ Date:_______________

Yes No Please check the appropriate box.

☐ ☐ Has there been a change in your health since your last dental appointment?

For what conditions? ______________________________________

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☐ ☐ Have you been in the hospital or emergency room for any reason in the past year?

For what conditions? ______________________________________

____

List medications (Prescription or Non-Prescription Drugs) currently being taken:

____

____

List Allergies ____

What is the best way to contact you for future appointments?

Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐

Number or Email: _________________________________

____________________	____________	____________________
Signature: Patient ☐ Parent ☐ Guardian ☐	Date	Reviewed By