MEDICAL HISTORY UPDATE

PATIENT NAME	TELEPHONE

MEDICAL HISTORY UPDATE Date____________________

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?____

Are you taking any kind of medication at this time? ☐ Yes ☐ No

If so, what____

Do you have any allergies (or adverse reactions) to any medications? ☐ Yes ☐ No

If so, what____

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Patient or Staff Member Signature