

MEDICAL HISTORY UPDATE

Patient Name: _____
Last
First
Middle

DOB: ____/____/____

Have there been any changes to your general health since last time you came to the clinic? _____

Please any change in the charts below

Date	Medical Update

NEW MEDICATIONS or change (Include prescribed, Over-the-counter and Herbal or Natural)			
Drug	Dose/Day	Date Started	Reason

SURGERIES (Include all the surgeries that you have undergone)		
Surgery	Date	Comments

SIGNATURE OF PATIENT: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand that it is very important to report any changes or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

Signature: _____ Date: _____

If other than the patient, indicate relationship: parent or legal guardian _____