Name _____

MEDICAL HISTORY UPDATE

	Yes	No
1. Have you been hospitalized or seen a physician in the last year?	_____	_____
2. Are you taking any prescription or non-prescription drugs, medicines or pills? Please list _____	_____	_____
3. Have you developed any allergies to medicines, drugs, dental anesthetics or metals? Please list _____	_____	_____
4. If female, are you pregnant, taking birth control pills, or taking bone density medications?	_____	_____
5. Have you developed any disease, condition or medical problem in the past year? Please list _____	_____	_____

_____ _____ _____

Date | Signature of Patient or Parent | Staff/Dentist Signature