MEDICAL HISTORY UPDATE FORM

Name_____ Date_____

Yes No

1. Have there been any changes in your medical history since your last visit to this office? If yes, please describe
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2. Have you been ill or hospitalized since your last visit to this office? If yes, please describe
_____
3. Have you been under the care of a physician since your last visit to this office? If yes, please describe
_____
4. Are you taking or have you taken regularly any medicine not listed on the previous history? If yes, please describe
_____
5. Do you now have a cold or sore throat?
6. Are you pregnant?

PT Signature_____ DDS Signature_____ Date_____

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