RECALL HISTORY

NAME: MR. /MRS. / MS. / DR.

EMAIL ADDRESS:

Please review your previous medical history (dated / /) and advise your dentist if there are any changes.

1. Has there been any changes in your health, such as serious illnesses, hospitalizations or new allergies? If yes, please specify. ☐ Yes ☐ No ☐ Not Sure/Maybe

2. Are you taking any new medications or has there been any change in your medications? If yes, please specify. ☐ Yes ☐ No ☐ Not Sure/Maybe

3. Have you has a heart murmur diagnosed or had any change in an existing cardiac problem or murmur? ☐ Yes ☐ No ☐ Not Sure/Maybe

4. When was your last medical checkup?

5. Were any problems identified? If yes, please explain. ☐ Yes ☐ No ☐ Not Sure/Maybe

6. **For women only:** Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date? ☐ Yes ☐ No ☐ Not Sure/Maybe

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE: **DATE:**

DENTIST SIGNATURE: **DATE:**

DENTIST NOTES: