RECALL HISTORY

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

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

1. Has there been any change 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 had a new heart problem diagnosed or had any change in an existing heart problem?

❑ 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 breastfeeding 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'S NOTES

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