

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