# 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 explain.

☐ Yes ☐ No ☐ Not Sure/Maybe

2. Are you taking any new medications or has there been any change in your medications? If yes, please explain.

☐ 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. 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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