Leo Family DENTAL

MEDICAL HISTORY UPDATE

Name: _____ Date of Birth: _____

Primary Physician: _____ Phone#: _____

Physician's Address: _____ Date of Last Physical Exam: _____

Did your physician advise you to **Pre-medicate** (ex. Antibiotic) prior to any dental procedures? YES NO

If YES, please explain: _____

Please CIRCLE and ANSWER the following questions. Thank You.

Do you have any **NEW** Food or/and Drug **Allergies**? YES NO

If YES, please list: _____

Were you admitted in the **Hospital** in the Past TWO YEARS? YES NO

If YES, please explain: _____

_____

Any **NEW Medical Conditions**? YES NO

If YES, please list: _____

_____

_____

List of **NEW Medications/Vitamins/Supplements**:

_____ _____

_____ _____

_____ _____

Please inform us of any medications that you are **NO LONGER** taking. Thanks.

Do you have any other diseases, conditions or problems not listed previously that you feel we should know about?

YES NO If YES, please describe: _____

_____

For Women: Are you pregnant? YES NO N/A

☐ NO CHANGES in my HEALTH HISTORY since the last time I filled out the medical history form.

*I, _____ have reviewed my previous medical history and made changes/updates above, also have disclosed **ALL** my health history to Leo Family Dental. I hereby certify that **ALL** the above information are true and correct to the best of my knowledge.*

Patient/Guardian Signature: _____ Date: _____

Patient Name (under 18 years old): _____ Date of Birth: _____

Reviewed by: _____ Dentist Signature: _____