MEDICAL HISTORY UPDATE

Patients Name: _____

Date: _____

1. Has your child seen a physician since his/her last visit? ____Yes ____ No
2. Has your child been to a hospital since his/her last visit? ____Yes ____ No
3. Has your child changed, added, or stopped taking any medications since his/her last visit? ____Yes ____No
4. Please list all the medications that your child is currently taking:
   Medication(s): _____ Reason: _____

5. Have there been any changes in your child's general health? ____Yes ____No
6. Does your child have any concerns you wish to discuss?

Comments: _____

Address change: _____

Insurance change: _____

Parents Signature: _____ Dentist's Signature: _____