ASC DENTAL STUDIO
YOUR SMILE. OUR PASSION.

Medical History Update

Patient Name:	Telephone:

Medical History Update --(1st visit) **Date: _____**

any change in your health since your last dental appointment? ☐ Yes ☐ No

If yes, what conditions? _____

Are you taking any kind of medications at this time? ☐ Yes ☐ No

If so, what? _____

any allergies (or adverse reactions) to any medications? ☐ Yes ☐ No

If so, what? _____

_____ _____

Patient Signature Doctor Signature

Medical History Update --(2nd visit) **Date: _____**

any change in your health since stated above? ☐ Yes ☐ No

If yes, what conditions? _____

Are you taking any kind of medications other than stated above? ☐ Yes ☐ No

If so, what? _____

any changes in allergies since stated above? ☐ Yes ☐ No

If so, what? _____

_____ _____

Patient Signature Doctor Signature

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