THAMES RIVER FAMILY DENTISTRY

CHANGES IN MEDICAL HISTORY

NAME: _____ BIRTH DATE: M_____D_____Y_____

Are there any changes to your health history? Yes ☐ No ☐ Please specify: _____

_____

_____

Have you changed your family physician? Yes ☐ No ☐ Name: _____
Phone: _____

Are you seeing a medical specialist? Yes ☐ No ☐
Specialist: _____ Phone: _____

WOMEN ONLY:
Are you pregnant? _____ Expected delivery date: _____ Breastfeeding: _____

List all the medications you are taking:_____

_____

Signature: _____ Date: _____