

Dr. Karen Calef's MEDICAL HISTORY UPDATES OR CHANGES-ADULT

Patient Name _____ **Date** _____

New dentist: _____

Address: _____

Last visit: _____ Reason: _____

New Physician: _____

Address: _____

Last visit: _____ Reason: _____

Medical condition: _____

Diagnosed when: _____

New medications: _____

List: _____ Being taken for: _____

Any other changes: _____

Signature _____ **Date** _____

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