SCARSDALE DENTAL GROUP

Creating Smiles for a Lifetime

Medical History Update or Supplement Form

Date (MM/DD/YYYY): ____/____/_____

Please Print Patient's Name: _____ _____
FIRST LAST

This Form is asking if there has been any updates to your Medical History since your last visit. The Medical History form is at http://www.scarsdaledentalgroup.org/ first-time-visit/ or available at the office.

Have your **Medications** including prescriptions, non-prescriptions, herbs, homeopathic remedies and other supplements changed since your last visit? YES____ NO____

If YES, please list all **Medications** below, and circle any **Medication** considered a Blood Thinner. .

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

9. _____ 10. _____

11. _____ 12. _____

Check if you have more than 12 Medicines? YES___ NO___ If YES, please write on them on Back of Form

Have you been diagnoses with any or new allergies? YES____ NO____

If YES, please list all Allergies, especially those to medications and Latex _____

Have you been hospitalized since last visit? YES____ NO____

If YES, please list reason _____

Has a doctor told you to pre-medicate prior to any dental procedures? YES____ NO____

If YES, please list the anti-biotic or other medication _____

Check if you have been diagnosed or experienced a new medical condition since your prior visit? YES____ NO____

If YES, please list the new condition _____

Check if you had knee, hip or joint replacement since your last visit? YES____ NO____

Check if you had any cardiac conditions occur such as heart valve replacement or bypass procedure since your last visit? YES____ NO___ If YES, please explain _____

Have you had any dental work done elsewhere since your last visit to Scarsdale Dental Group? YES____ NO___

If YES, please explain _____

Smiles@Scarsdaledentalgroup.com Office Phone: 914-723-4707