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Please complete this form by answering the questions. Chief Complaint: All details will be strictly confidential. Are you under a physician's care now? Are you taking any medications, pills, or drugs? Have you ever been hospitalized or had a major operation? Have you ever had any complications following dental treatment? Are you a smoker? Do you have, or have you had any of the following High Blood Pressure Asthma Heart Attack Epilepsy Leukemia Heart Disease Kidney Disease Itiver Disease Thyroid Problem Diabetes Tuberculosis Hepatitis/Jaundice Creutzfeldt-Jakob disease (CID) Others, Please Specify Are you allergic, or have you reacted adversely to any of the following: Ves No Others, Please Specify Presser Specify Asthma Asthma Heart Attack Epilepsy Leukemia Heart Disease Tuberculosis Hepatitis/Jaundice Others, Please Specify Are you allergic, or have you reacted adversely to any of the following: Ves No Others, Please Specify Asperin or Ibuprofen Reactions to metals Latex or rubber dam Foods Additional questions for women. Are you taking oral contraceptives? PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY No Pain Moderate Pain Worst Pain						
Date of Birth: 2012 10 15 sex: M F Nationality: 8 10 5 h How do you know about us? Family or Friends Internet Newspapers Tothers MEDICAL HISTORY Certain medical conditions can affect dental treatment and vice versa. Please complete this form by answering the questions. Chief Complaint: All details will be strictly confidential. Are you under a physician's care now? Have you over been hospitalized or had a major operation? Have you ever been hospitalized or had a major operation? Have you aver had any complications following dental treatment? Are you as moker? High Blood Pressure Low Blood Pressure Rheumatic Fever Fainting / Seizures O syu have, or have you had any of the following High Blood Pressure Low Blood Pressure Rheumatic Fever Fainting / Seizures Asthma Heart Attack Epilepsy Leukemia Heart Disease Liver Disease Loung Disease Thyroid Problem Diabetes Tuberculosis Hepatitis/Jaundice Stroke Arthrits Cancer AlDS/HIV Infection Creutzfeldt-lakob disease (CID) Others, Please Specify Are you allergic, or have you reacted adversely to any of the following: Ves No Others, Please Specify Are you allergic, or have you reacted adversely to any of the following: Ves No Others, Please Specify Are you taking oral contraceptives? Penicillin or other antibiotics Additional questions for women. Are you taking oral contraceptives? PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY Worst Pain Moderate Pain Worst Pain Moderate Pain Worst Pain	Name: Amelia Dann					
How do you know about us? Family or Friends	Mobile no.: Email:					
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To the best of my knowledge, all of the preceding answer and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.