

File No: 1821

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|--|-------|----------|------------------------|
| Name: MANDEEP SINGH WACH | | | |
| Mobile no.: 0558463018 Email: mswalla 2012 | le . | gma | il. com |
| Date of Birth: 16/05/1988 Sex: OM OF | | onality: | MOIAN |
| How do you know about us? | ○ Ne | ewspape | ers Others |
| MEDICAL HISTORY | | | |
| Certain medical conditions can affect dental treatment and vice versa. | | | |
| Please complete this form by answering the questions. | | | |
| Chief Complaint: ROOT CANK CROWN CKANING CHE | chul | 0 | |
| All details will be strictly confidential. | Yes | No | Others, Please Specify |
| Are you under a physician's care now? | | V | |
| Are you taking any medications, pills, or drugs? | | V | |
| Have you ever been hospitalized or had a major operation? | | V | |
| Have you ever had any complications following dental treatment? | | V | |
| Are you a smoker? | | V | |
| Do you have, or have you had any of the following | | | |
| ○ High Blood Pressure ○ Low Blood Pressure ○ Rheumatic Feve | er | | Fainting / Seizures |
| Asthma Heart Attack Epilepsy | | | O Leukemia |
| Heart Disease Cidney Disease Liver Disease Lung Disease | | | |
| ○ Thyroid Problem ○ Diabetes ○ Tuberculosis | | | Hepatitis/Jaundice |
| O Stroke O Arthritis O Cancer | | | AIDS/HIV Infection |
| Creutzfeldt–Jakob disease (CJD) Others, Please Specify | | | |
| Are you allergic, or have you reacted adversely to any of the following: | Yes | No | Others, Please Specify |
| Local anesthetics (Novocaine) | | | • • |
| Penicillin or other antibiotics | | | |
| Asperin or Ibuprofen | | | |
| Reactions to metals | | | |
| Latex or rubber dam | | | |
| Foods | V | | PHAWN |
| Additional questions for women. | Yes | No | Others, Please Specify |
| Are you pregnant or trying to get pregnant? | | 170 | |
| if yes, expected delivery date: | | | |
| Are you taking oral contraceptives? | | | |
| PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR C | URREN | T PAIN I | NTENSITY |
| NO Pain OOO A A B B B B B B B B B B B | | | |
| No Pain Moderate Pain Worst Pain 0 1 2 3 4 5 6 7 8 9 10 | | | |
| 5 1 2 5 7 5 0 | | 0 | _ |

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.