

File No:

1835

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Name: DANIEL WALTON			
Mobile no.: 0566375650 Email: DWGLAZING	G G	HOT	MAIL.CO.UE
Date of Birth: 15 - 1 - 1991 Sex: M OF	Nationality: ENGLISH		
How do you know about us?		ewspap	
MEDICAL HISTORY			
Certain medical conditions can affect dental treatment and vice ve	ersa.		
Please complete this form by answering the questions.			
thief Complaint:			
All details will be strictly confidential.	Yes	No	Others, Please Specify
•	163		Others, Flease Specify
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	er		Fainting / Seizures
Asthma Heart Attack Epilepsy	Leukemia		
Heart Disease	Lung Disease		
Thyroid Problem Diabetes Tuberculosis	Hepatitis/Jaundice		
Stroke Arthritis Cancer	AIDS/HIV Infection		
Creutzfeldt–Jakob disease (CJD) Others, Please S	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		1	
Additional questions for women.	Yes	No	Others, Please Specify
Are you pregnant or trying to get pregnant?			
if yes, expected delivery date:			
Are you taking oral contraceptives?			
PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR C	URREN	T PAIN	INTENSITY
NO Pain No Pain			