



File No:

1862

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|---|---|----------------------------|--|
| Name: <u>Aahana Kunal Pandit</u> | | | |
| Mobile no.: <u>0563209990</u> | Email: <u>amruta.pandit22@yahoo.com</u> | | |
| Date of Birth: <u>23/04/2013</u> | Sex: <input type="radio"/> M <input checked="" type="radio"/> F | Nationality: <u>Indian</u> | |
| How do you know about us? <input type="radio"/> Family or Friends <input type="radio"/> Internet <input type="radio"/> Newspapers <input checked="" type="radio"/> Others | | | |

MEDICAL HISTORY

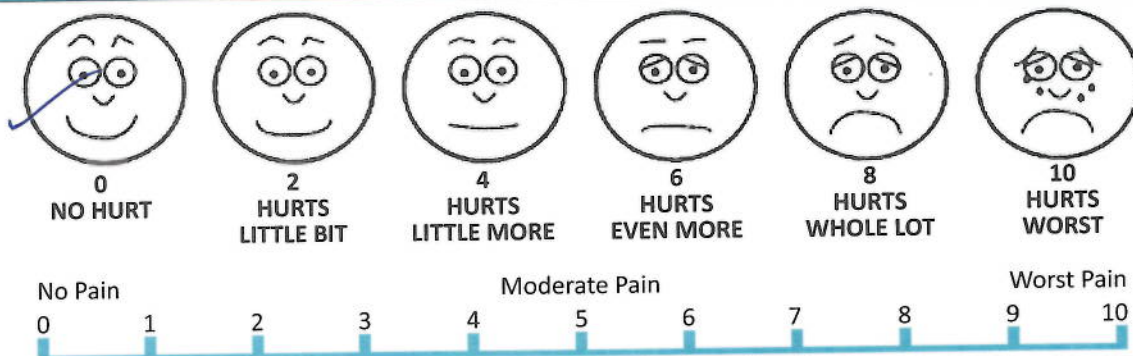
Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

Chief Complaint: _____

| All details will be strictly confidential. | Yes | No | Others, Please Specify |
|---|---|--|--|
| Are you under a physician's care now? | | <input checked="" type="checkbox"/> | |
| Are you taking any medications, pills, or drugs? | | <input checked="" type="checkbox"/> | |
| Have you ever been hospitalized or had a major operation? | | <input checked="" type="checkbox"/> | |
| Have you ever had any complications following dental treatment? | | <input checked="" type="checkbox"/> | |
| Are you a smoker? | | <input checked="" type="checkbox"/> | |
| Do you have, or have you had any of the following | | | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting / Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis/Jaundice |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> AIDS/HIV Infection |
| <input type="checkbox"/> Creutzfeldt-Jakob disease (CJD) | <input type="checkbox"/> Others, Please Specify _____ | | |
| Are you allergic, or have you reacted adversely to any of the following: | | | |
| Local anesthetics (Novocaine) | | | <u>don't know yet</u> |
| Penicillin or other antibiotics | | | <u>don't know yet</u> |
| Asperin or Ibuprofen | | <input checked="" type="checkbox"/> | |
| Reactions to metals | | <input checked="" type="checkbox"/> | |
| Latex or rubber dam | | <input checked="" type="checkbox"/> | |
| Foods | | <input checked="" type="checkbox"/> | |
| Additional questions for women. | | | |
| Are you pregnant or trying to get pregnant? | | <input checked="" type="checkbox"/> | <u>.NA</u> |
| if yes, expected delivery date: _____ | | | |
| Are you taking oral contraceptives? | | | <u>NA</u> |

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY



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.