



# DENTISTREE DENTAL CLINIC

File No:

1877

Name: Sreesith Padmanabhan Nair  
 Mobile no.: \_\_\_\_\_ Email: Sreesithpulinat@gmail.com  
 Date of Birth: 30/05/1984 Sex:  M  F Nationality: \_\_\_\_\_  
 How do you know about us?  Family or Friends  Internet  Newspapers  Others

## MEDICAL HISTORY

Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

Chief Complaint: Tooth pain.

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 - No -

- |  |   |  |  |
|--|---|--|--|
| <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:

	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)			
Penicillin or other antibiotics			
Asperin or Ibuprofen			
Reactions to metals			
Latex or rubber dam			
Foods	<input checked="" type="checkbox"/>		<u> Prawns </u>

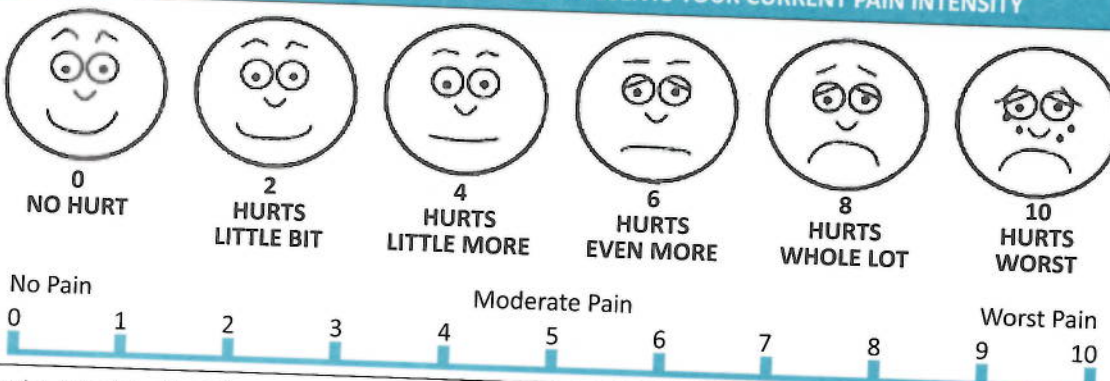
Additional questions for women.

Are you pregnant or trying to get pregnant? Yes No Others, Please Specify

if yes, expected delivery date: \_\_\_\_\_

Are you taking oral contraceptives? \_\_\_\_\_

### 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.