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Mobile no.: Ox 11840 a 9 Email: Ox 0x	Name: Anju Surendran			
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MEDICAL HISTORY  Certain medical conditions can affect dental treatment and vice versa.  Please complete this form by answering the questions.  Chilef Complaint:  All details will be strictly confidential.  Are you under a physician's care now?  Are you under a physician's care now?  Are you under a physician's care now?  Are you taking any medications, pills, or drugs?  Have you ever bean 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  Low Blood Pressure  Rheumatic Fever  Fainting / Seizures  Asthma  Heart Attack  Epilepsy  Leukemia  Heart Disease  Kidney Disease  Liver Disease  Liver Disease  Tupberculosis  Hepatitis/Jaundice  Arbritis  Cancer  AIDS/HIV Infection  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  Others, Please Specify  Additional questions for women.  Are you taking oral contraceptives?  PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY  WHOLE LOT  WHORST  NO OTHERS.  WHOLE LOT  WHORST  WHOLE LOT  WORST				
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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.