



# DENTISTREE DENTAL CLINIC

File No:

1911

Name: RAVINDRA GUPTA

Mobile no.: 0565004710 Email: \_\_\_\_\_

Date of Birth: 01 Feb 1965 Sex:  M  F Nationality: Indian

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: \_\_\_\_\_

All details will be strictly confidential.

	Yes	No	Others, Please Specify
Are you under a physician's care now?			
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 checked="" 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 _____ |  |  |

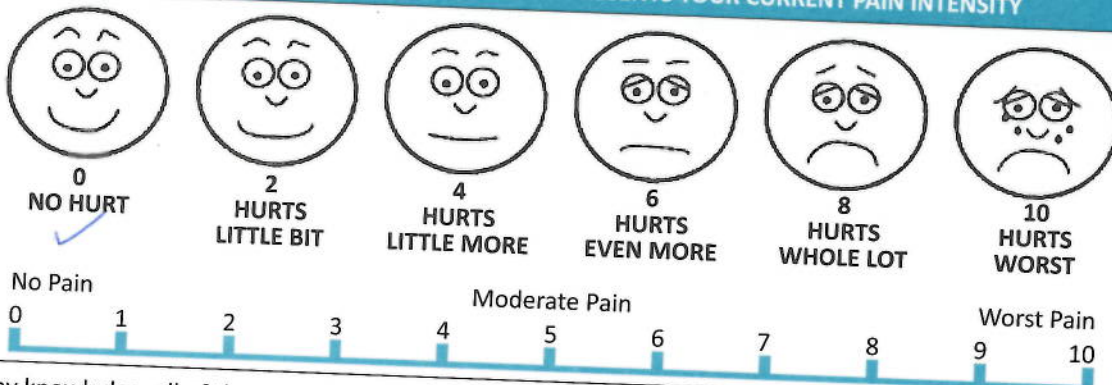
Are you allergic, or have you reacted adversely to any of the following:

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

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 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.