

File No:

Date of Birth: OHO 9 2013 Sex: OM OF How do you know about us? OFamily or Friends OInternet MEDICAL HISTORY Certain medical conditions can affect dental treatment and vice very Please complete this form by answering the questions. Inief Complaint: OR Please complete this form by answering the questions. Inief Complaint: OF AIR QUESTION OF THE COMP OF THE	Nation O New	vspape	ers O Others
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High Blood Pressure			
High Blood Pressure	_		
Asthma Heart Attack Epilepsy Heart Disease Kidney Disease Liver Disease			7 5-1-11 (5)
Heart Disease		-	Fainting / Seizures
) =		->	Leukemia
Thyroid Problem Diabetes Tuberculosis			Lung Disease
Stroke Arthritis Cancer		_	Hepatitis/Jaundice
Creutzfeldt–Jakob disease (CJD) Others, Please Spec	cify		AIDS/HIV Infection
re you allergic, or have you reacted adversely to any of the following:	T	1-	Out Bl a se
ocal anesthetics (Novocaine)	E3 1	lo	Others, Please Specify
enicillin or other antibiotics			
sperin or Ibuprofen			
eactions to metals			
atex or rubber dam	-		
pods	4	-	
dditional questions for women.	es N		Othors Diseas Courts
re you pregnant or trying to get pregnant?	- 16		Others, Please Specify
yes, expected delivery date:			
e you taking oral contraceptives?			
PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURR	PENT DA	IN INT	ENCITY

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.