DENTISTREE DENTAL CLINIC

File No:

Name: Chafai Yassamina			
Mobile no.: 971558450331	Email:		
Date of Birth: 03/08/1992	Sex: ○ M ☒ F	Nationality: Algerian.	
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?		X	
Are you taking any medications, pills, or drugs?	X		Panadol + Clamoxyl.
Have you ever been hospitalized or had a major operation?		X	
Have you ever had any complications following dental treatment?		X	
Are you a smoker?		X	

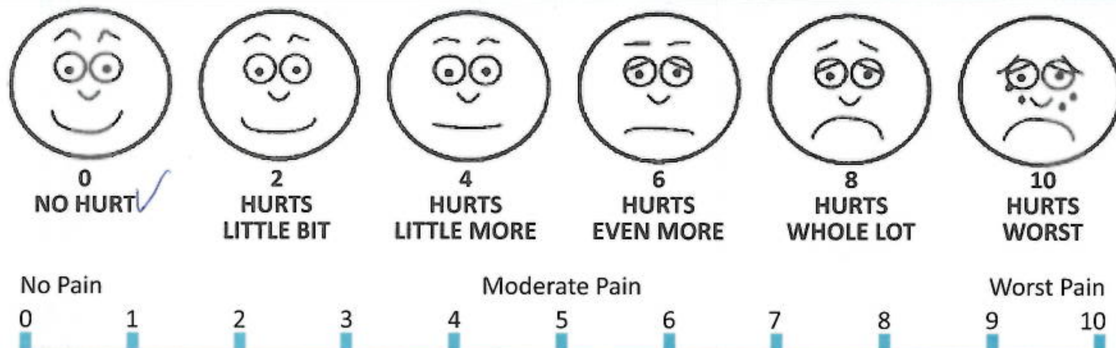
Do you have, or have you had any of the following

○ High Blood Pressure	○ Low Blood Pressure	○ Rheumatic Fever	○ Fainting / Seizures
○ Asthma	○ Heart Attack	○ Epilepsy	○ Leukemia
○ Heart Disease	○ Kidney Disease	○ Liver Disease	○ Lung Disease
○ Thyroid Problem	○ Diabetes	○ Tuberculosis	○ Hepatitis/Jaundice
○ Stroke	○ Arthritis	○ Cancer	○ AIDS/HIV Infection
○ Creutzfeldt–Jakob disease (CJD)		○ Others, Please Specify ______	

Are you allergic, or have you reacted adversely to any of the following:	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)		X	
Penicillin or other antibiotics		X	
Asperin or Ibuprofen		X	
Reactions to metals		X	
Latex or rubber dam		X	
Foods		X	

Additional questions for women.	Yes	No	Others, Please Specify
Are you pregnant or trying to get pregnant?		X	
if yes, expected delivery date: ______			
Are you taking oral contraceptives?		X	

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.