



File No:

1977

Name: Cherry Ann Camilo

Mobile no.: 0505103373 Email: \_\_\_\_\_

Date of Birth: 25/02/1993 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: \_\_\_\_\_

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

- |  |  |  |  |
|--|--|--|--|
| <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 checked="" type="checkbox"/> Others, Please Specify <u>Iron Deficiency (anemic)</u> |  |  |

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

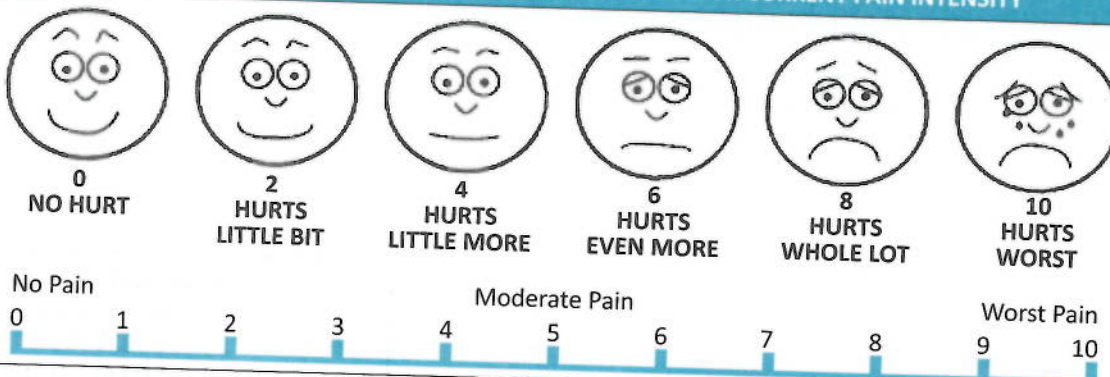
	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)		<input checked="" type="checkbox"/>	
Penicillin or other antibiotics		<input checked="" type="checkbox"/>	
Asperin or Ibuprofen		<input checked="" type="checkbox"/>	
Reactions to metals		<input checked="" type="checkbox"/>	
Latex or rubber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

Additional questions for women.

	Yes	No	Others, Please Specify
Are you pregnant or trying to get pregnant?		<input checked="" type="checkbox"/>	
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.