



Name: DEVINDER KUMAR

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Date of Birth: 08-03-1960 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?   |     |                                     |                        |

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 checked="" type="checkbox"/> Heart Attack      | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Leukemia            |
| <input checked="" 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 _____ |  |  |

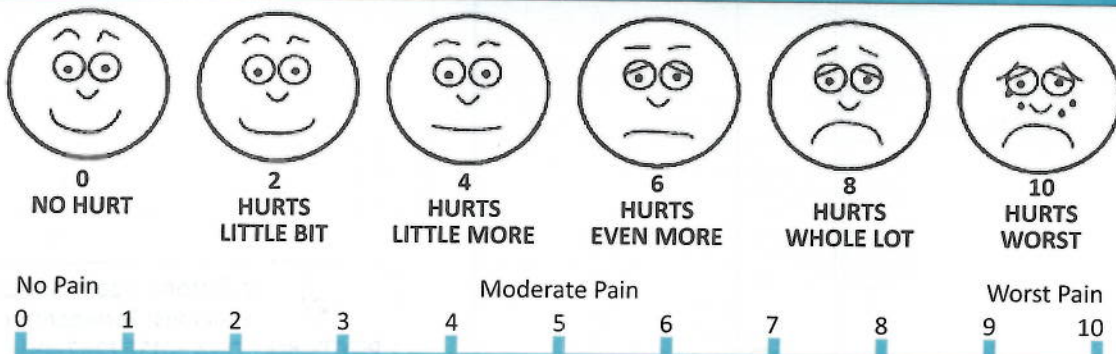
Are you allergic, or have you reacted adversely to any of the following:

|                                 | Yes | No                                  | Others, Please Specify |
|---------------------------------|-----|-------------------------------------|------------------------|
| Local anesthetics (Novocaine)   |     | <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? |     |    |                        |
| 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.