



DENTISTREE DENTAL CLINIC

File No:

2040

Name: ECAINE DACRUZ

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Date of Birth: 09-07-1984

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: CLEAN UP + CAVITIES

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="radio"/> High Blood Pressure | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Rheumatic Fever | <input type="radio"/> Fainting / Seizures |
| <input type="radio"/> Asthma | <input type="radio"/> Heart Attack | <input type="radio"/> Epilepsy | <input type="radio"/> Leukemia |
| <input type="radio"/> Heart Disease | <input type="radio"/> Kidney Disease | <input type="radio"/> Liver Disease | <input type="radio"/> Lung Disease |
| <input type="radio"/> Thyroid Problem | <input type="radio"/> Diabetes | <input type="radio"/> Tuberculosis | <input type="radio"/> Hepatitis/Jaundice |
| <input type="radio"/> Stroke | <input type="radio"/> Arthritis | <input type="radio"/> Cancer | <input type="radio"/> AIDS/HIV Infection |
| <input type="radio"/> Creutzfeldt-Jakob disease (CJD) | <input type="radio"/> 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.

Are you pregnant or trying to get pregnant? Yes No Others, Please Specify BREAST FEEDING

if yes, expected delivery date: _____

Are you taking oral contraceptives? Yes No

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY



0 NO HURT



2 HURTS LITTLE BIT



4 HURTS LITTLE MORE



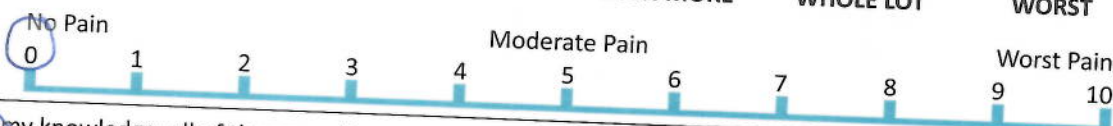
6 HURTS EVEN MORE



8 HURTS WHOLE LOT



10 HURTS WORST



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.

[Handwritten signature]