

File No: Name: ARNAUD Eve-lise Email: evelise, arnoud. ela @ gmail. com Mobile no.: +33 6 10346487 Date of Birth: 10107/1992 $\bigcirc M$ O-F Nationality: French How do you know about us? O Family or Friends Internet Newspapers **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? lest inner ear 5 himes. 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? Casual. 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) L Penicillin or other antibiotics X Asperin or Ibuprofen X Reactions to metals × Latex or rubber dam Foods Additional guestions 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 NO HURT **HURTS HURTS HURTS HURTS HURTS** LITTLE BIT LITTLE MORE **EVEN MORE** WHOLE LOT 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.

Moderate Pain

Worst Pain

10

No Pain