



Name: MANISHA KOTECCHA

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Date of Birth: 30-08-69

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"/>	<input type="checkbox"/>	
Are you taking any medications, pills, or drugs?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Have you ever been hospitalized or had a major operation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Have you ever had any complications following dental treatment?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Are you a smoker?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

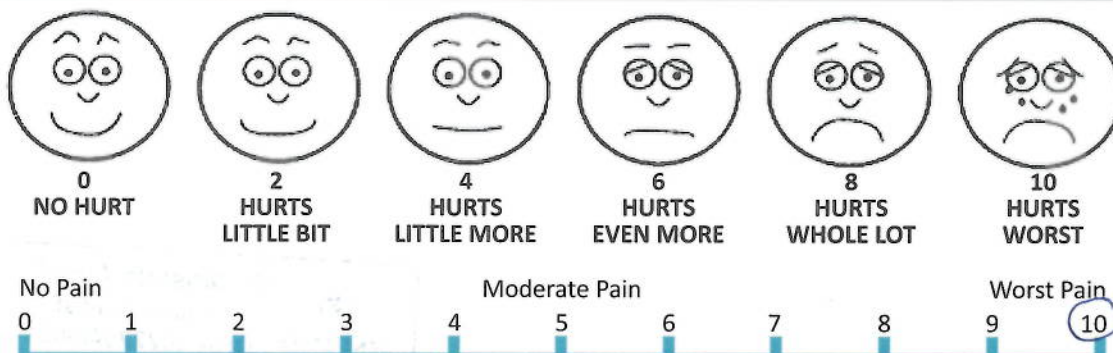
Do you have, or have you had any of the following

- |   |   |                                       |   |
|---|---|---------------------------------------|---|
| <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 <u>cholesterol</u> |                                       |   |

Are you allergic, or have you reacted adversely to any of the following:	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Penicillin or other antibiotics	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Asperin or Ibuprofen	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Reactions to metals	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Latex or rubber dam	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Foods	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

Additional questions for women.	Yes	No	Others, Please Specify
Are you pregnant or trying to get pregnant?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
if yes, expected delivery date: _____			
Are you taking oral contraceptives?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

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.