

File No: 2194

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Name: Neil Dadlani			
Mobile no.: 056 2118909 Email: dadlanineil	o h	ohr	rail com
Date of Birth: 29/07/2001 Sex: OM OF		nality:	
How do you know about us?	○ Ne	wspape	ers Others
MEDICAL HISTORY	4	State of	
Certain medical conditions can affect dental treatment and vice v	ersa.		
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?		/	
Are you taking any medications, pills, or drugs?		/	
Have you ever been hospitalized or had a major operation?		/	
Have you ever had any complications following dental treatment?			
Are you a smoker?		/	
Do you have, or have you had any of the following			
○ High Blood Pressure ○ Low Blood Pressure ○ Rheumatic Feve	er		Fainting / Seizures
Asthma Heart Attack Epilepsy	C Leukemia		
○ Heart Disease ○ Kidney Disease ○ Liver Disease	C Lung Disease		
○ Thyroid Problem ○ Diabetes ○ Tuberculosis	O 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)		/	
Penicillin or other antibiotics		-	
Asperin or Ibuprofen		/	
Reactions to metals		/	
Latex or rubber dam			
Foods		-	
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 O	CURRENT	PAIN I	NTENSITY
NO HURT HURTS HURTS HURTS EVEN MORE	HU	8 JRTS LE LOT	
No Pain Moderate Pain   0 1 2 3 4 5 6	7	8	Worst Pain 9 10
0 1 2 3 4 3 0	_	0	3 10

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.