

File No: 2189

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Name: JAIMON M JOSEOF			
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	-	onality:	MAIGH INDIAN
How do you know about us?	rnet ON	ewspape	
MEDICAL HIST	ORY		
Certain medical conditions can affect dental treatment an			
Please complete this form by answering the questions.			
Chief Complaint:			
All details will be strictly confidential.	Yes	No	Others, Please Specify
	163	140	Others, Flease 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			<u> </u>
Asthma			
Heart Disease			
Thyroid Problem Diabetes Tuberculosis Hepatitis/Jaundice			Ā
Stroke Arthritis Cance			AIDS/HIV Infection
	rs, 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 REPRESEN	TS YOUR CURREN	T PAIN IN	ITENSITY
LITTLE BIT LITTLE MORE EVEN		8 JRTS DLE LOT	10 HURTS WORST
No Pain Moderate Pain		-	Worst Pain
0 1 2 3 4 5	6 7	8	9 10