



Name: <u>Yana Melnik</u>			
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Date of Birth: <u>14.08.1993</u>	Sex: <input type="radio"/> M <input type="radio"/> F	Nationality:	
How do you know about us? <input checked="" type="radio"/> Family or Friends <input type="radio"/> Internet <input type="radio"/> Newspapers <input type="radio"/> 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"/>	
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 checked="" 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 _____ | | |

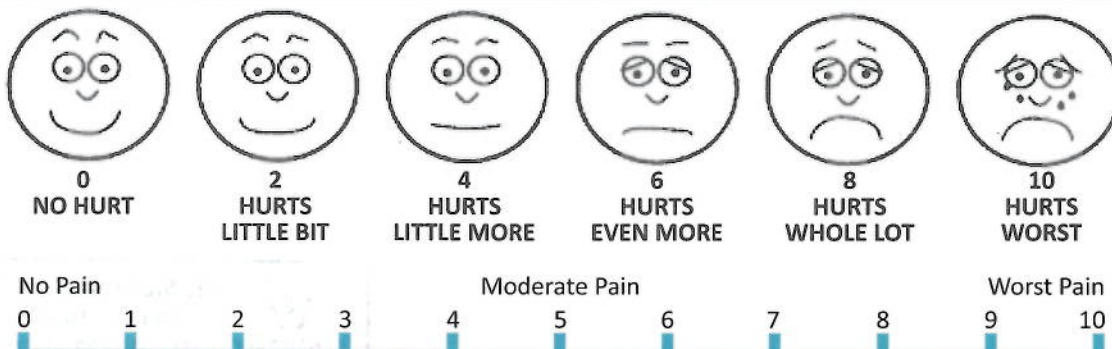
Are you allergic, or have you reacted adversely to any of the following:

	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.

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