



File No:

2779

Name: <u>Divij Vinay Bhatia</u>			
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Date of Birth: <u>19 Jun 2017</u>	Sex: <input checked="" type="radio"/> M <input type="radio"/> F	Nationality: <u>Indian</u>	
How do you know about us? <input 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: General checkup.

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="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting / Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Leukemia |
| <input checked="" type="checkbox"/> Heart Disease | <input checked="" type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis/Jaundice |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> AIDS/HIV Infection |
| <input type="checkbox"/> Creutzfeldt-Jakob disease (CJD) | <input checked="" type="checkbox"/> Others, Please Specify <u>Too much to mention here.</u> | | |

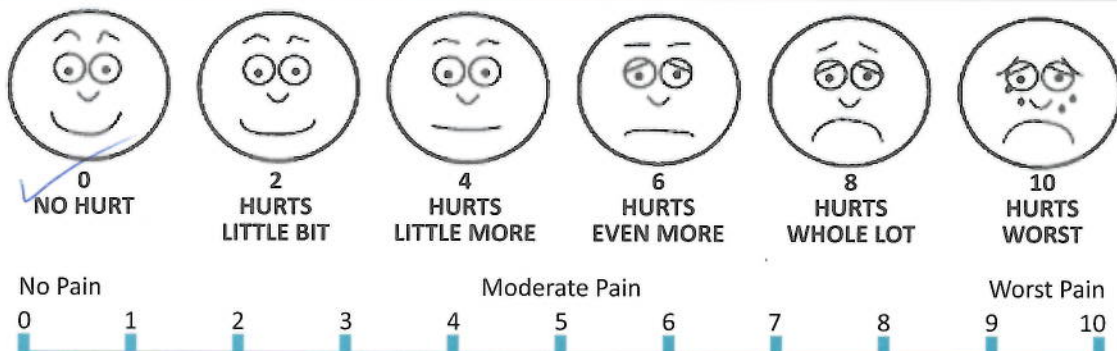
Are you allergic, or have you reacted adversely to any of the following:

	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)	<input checked="" type="checkbox"/>		<u>Propofol.</u>
Penicillin or other antibiotics		<input checked="" type="checkbox"/>	
Asperin or Ibuprofen	<input checked="" type="checkbox"/>		<u>Brufen not allowed</u>
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?			
if yes, expected delivery date: _____			
Are you taking oral contraceptives?			

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.