



File No:

224

|  |   |                            |  |
|--|---|----------------------------|--|
| Name: <u>MEENA</u>   |   |                            |  |
| Mobile no.: <u>050-6135937</u>   | Email:  |                            |  |
| Date of Birth: <u>12-12-1964</u>   | Sex: <input type="radio"/> M <input checked="" 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: \_\_\_\_\_

| 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"/> |                                     | <u>BP medicine</u>     |
| Have you ever been hospitalized or had a major operation?       |                                     | <input checked="" type="checkbox"/> |                        |
| Have you ever had any complications following dental treatment? |                                     |                                     |                        |
| Are you a smoker?   |                                     | <input checked="" type="checkbox"/> |                        |

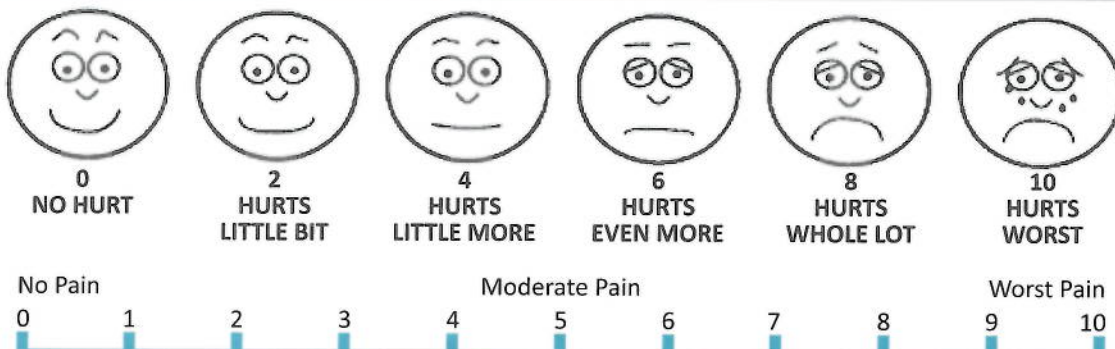
Do you have, or have you had any of the following

|  |   |  |  |
|--|---|--|--|
| <input checked="" 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 type="checkbox"/> Heart Disease                   | <input 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 type="checkbox"/> 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   | <input checked="" type="checkbox"/> |    |                        |
| 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? |     | <input checked="" type="checkbox"/> |                        |
| 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.