DENTISTREE DENTAL CLINIC

File No: 2366

Name: Lata			
Mobile no.: 0506577721	Email: Lata.Mulchandani@gmail		
Date of Birth:	Sex: ○ M ○ F	Nationality:	
How do you know about us?	○ Family or Friends	⦿ Internet	○ Newspapers ○ 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?			
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?			

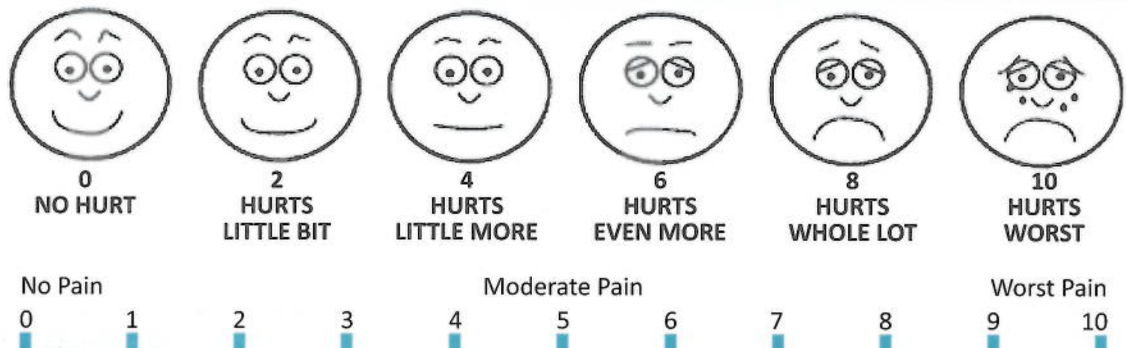
Do you have, or have you had any of the following

⊘ High Blood Pressure	⊘ Low Blood Pressure	⊘ Rheumatic Fever	⊘ Fainting / Seizures
⊘ Asthma	⊘ Heart Attack	⊘ Epilepsy	⊘ Leukemia
⊘ Heart Disease	⊘ Kidney Disease	⊘ Liver Disease	⊘ Lung Disease
⊘ Thyroid Problem	⊘ Diabetes	⊘ Tuberculosis	⊘ 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 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.