



File No:

2426

Name: <u>VANDANA</u>			
Mobile no.: <u>050 6989091</u>	Email: <u>Vandana.kanjani@hotmail.com</u>		
Date of Birth: <u>26-11-1955</u>	Sex: <input checked="" type="radio"/> F <input type="radio"/> M <input type="radio"/> F	Nationality: <u>INDIAN</u>	
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: _____

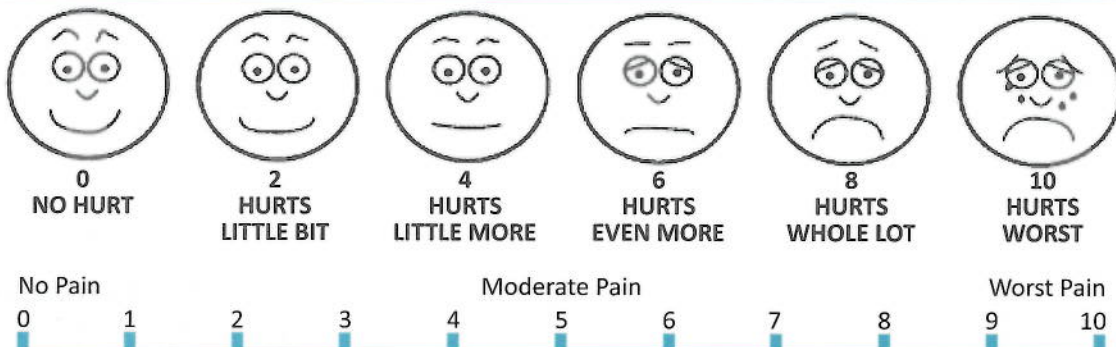
All details will be strictly confidential.	Yes	No	Others, Please Specify
Are you under a physician's care now?		<input checked="" type="checkbox"/>	
Are you taking any medications, pills, or drugs?		<input checked="" type="checkbox"/>	
Have you ever been hospitalized or had a major operation?		<input 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 checked="" type="checkbox"/> High Blood Pressure	<input checked="" type="checkbox"/> Low Blood Pressure	<input checked="" type="checkbox"/> Rheumatic Fever	<input checked="" type="checkbox"/> Fainting / Seizures
<input checked="" type="checkbox"/> Asthma	<input checked="" type="checkbox"/> Heart Attack	<input checked="" type="checkbox"/> Epilepsy	<input checked="" type="checkbox"/> Leukemia
<input checked="" type="checkbox"/> Heart Disease	<input checked="" type="checkbox"/> Kidney Disease	<input checked="" type="checkbox"/> Liver Disease	<input checked="" type="checkbox"/> Lung Disease
<input checked="" type="checkbox"/> Thyroid Problem	<input checked="" type="checkbox"/> Diabetes	<input checked="" type="checkbox"/> Tuberculosis	<input checked="" type="checkbox"/> Hepatitis/Jaundice
<input checked="" type="checkbox"/> Stroke	<input checked="" type="checkbox"/> Arthritis	<input checked="" type="checkbox"/> Cancer	<input type="checkbox"/> AIDS/HIV Infection
<input checked="" type="checkbox"/> Creutzfeldt-Jakob disease (CJD)	<input checked="" type="checkbox"/> Others, Please Specify <u>Peptic ulcer</u>		

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"/>		<u>Septtran allergy</u>
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.