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|------------------------------|--|--------------------------------|---|
| Name: <u>BAL KRISHNAN</u> | | | |
| Mobile no.: <u>021000818</u> | Email: | | |
| Date of Birth: | Sex: <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? | | ✓ | |
| 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? | ✓ | | |

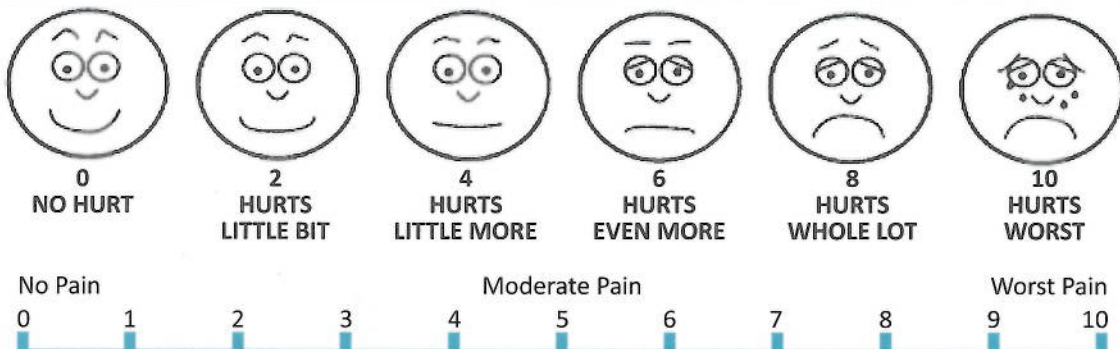
Do you have, or have you had any of the following

| | | | |
|---|--|---------------------------------------|---|
| <input type="radio"/> High Blood Pressure | <input checked="" 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 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) | | | |
| 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.