DENTISTREE DENTAL CLINIC

File No: 2998

Name:	SHAHAB KROOP		
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Date of Birth:	01/02/94	Sex:	~~O~~ M O F
Nationality:	NORWAY		

How do you know about us? O Family or Friends ~~O~~ Internet O Newspapers O 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?		✗	

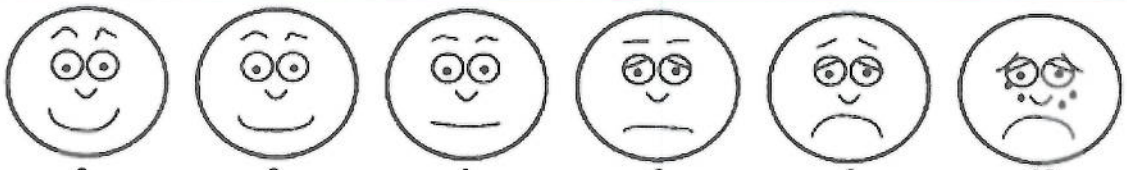
Do you have, or have you had any of the following

O High Blood Pressure	O Low Blood Pressure	O Rheumatic Fever	O Fainting / Seizures
O Asthma	O Heart Attack	O Epilepsy	O Leukemia
O Heart Disease	O Kidney Disease	O Liver Disease	O Lung Disease
O Thyroid Problem	O Diabetes	O Tuberculosis	O Hepatitis/Jaundice
O Stroke	O Arthritis	O Cancer	O AIDS/HIV Infection
O Creutzfeldt–Jakob disease (CJD)		O 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



0	2	4	6	8	10
NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST

No Pain — Moderate Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

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.