



File No:

245

|                           |  |                                |   |
|---------------------------|--|--------------------------------|---|
| Name: Syed Hayyan         |  |                                |   |
| Mobile no.: 052-8691855   | Email: syedhayyan@hotmail.com                        |                                |   |
| Date of Birth: 26/11/2002 | Sex: <input type="radio"/> M <input type="radio"/> F | Nationality:                   |   |
| 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"/> |                        |




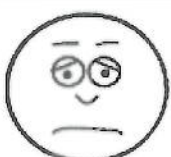

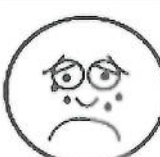
**Do you have, or have you had any of the following**

|  |   |  |  |
|--|---|--|--|
| <input 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)  |     | <input checked="" type="checkbox"/> |                        |
| Penicillin or other antibiotics  |     | <input checked="" type="checkbox"/> |                        |
| Asperin or Ibuprofen   |     | <input checked="" type="checkbox"/> |                        |
| Reactions to metals  |     | <input checked="" type="checkbox"/> |                        |
| Latex or rubber dam  |     | <input checked="" type="checkbox"/> |                        |
| Foods  |     | <input checked="" type="checkbox"/> |                        |

| 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?         |     | <input checked="" type="checkbox"/> |                        |

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY

|   |   |   |   |  |   |   |   |   |   |    |
|---|---|---|---|--|---|---|---|---|---|----|
|  |  |  |  |  |  |   |   |   |   |    |
| 0<br>NO HURT  | 2<br>HURTS<br>LITTLE BIT  | 4<br>HURTS<br>LITTLE MORE   | 6<br>HURTS<br>EVEN MORE   | 8<br>HURTS<br>WHOLE LOT  | 10<br>HURTS<br>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.