# DENTISTREE DENTAL CLINIC

File No: 2600

| | | | |
|---|---|---|---|
| Name: | MANUEL HOLLINGER | | |
| Mobile no.: | 0589886778 | Email: | MANUELHOLLINGER2@GMAIL.COM |
| Date of Birth: | 31/07/1994 | 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? | | X | |
| Are you taking any medications, pills, or drugs? | | X | |
| Have you ever been hospitalized or had a major operation? | X | | |
| Have you ever had any complications following dental treatment? | | X | |
| Are you a smoker? | | X | USED TO BE |

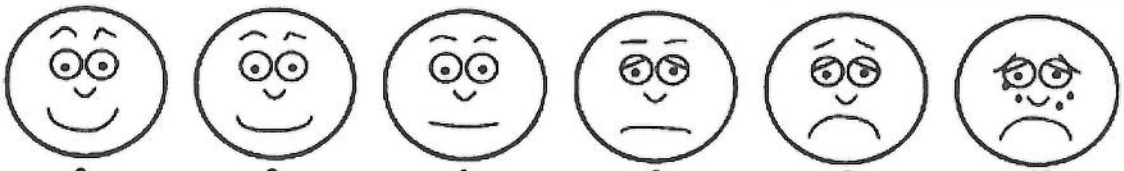
**Do you have, or have you had any of the following**

| | | | |
|---|---|---|---|
| ○ 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**



| 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.