

File No: 2835

Mobile no.: 05255 00896 Email: 15(qmm) Date of Birth: 17 1901 Sex: 04 OF			
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Date of Birth: 19 27 1921 Sex: OM OF		onality:	LAND TIEN
How do you know about us?	- in the last	ewspape	o Others
MEDICAL HISTORY	a) Vá		
Certain medical conditions can affect dental treatment and vice	versa.		
Please complete this form by answering the questions.			
hief 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			
High Blood Pressure	/er		Fainting / Seizures
Asthma Heart Attack Epilepsy			Leukemia
Heart Disease Civer 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		1	
Additional questions for women.	Yes	No	Others, Please Specify
Are you pregnant or trying to get pregnant?			
f yes, expected delivery date:			
Are you taking oral contraceptives?			
	CLIDDEN	T PAIN II	UTENICITY.

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.