

File No: Name: Vaterico Mobile no.: (\*) Email: Date of Birth: 28 /011 1930 Sex: OM € F Nationality: How do you know about us? O Family or Friends O 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? 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 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 NO HURT **HURTS HURTS HURTS HURTS HURTS** 

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.

Moderate Pain

**EVEN MORE** 

WHOLE LOT

WORST

Worst Pain

LITTLE MORE

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.

LITTLE BIT

No Pain