

Please complete this form by answering the questions.

Email: 305

Sex:

Family or Friends

Low Blood Pressure

Heart Attack

Diabetes

Arthritis

Are you allergic, or have you reacted adversely to any of the following:

Kidney Disease

OM.

MEDICAL HISTORY

OF

OInternet

Epilepsy

Cancer

Mobile no .: + 9 2 1 5 8 5 8 8 00 6 2

All details will be strictly confidential.

Are you under a physician's care now?

Are you taking any medications, pills, or drugs?

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

Have you ever been hospitalized or had a major operation?

Have you ever had any complications following dental treatment?

How do you know about us?

Name: \oC

Date of Birth:

Chief Complaint:

Are you a smoker?

Asthma

Stroke

Asperin or Ibuprofen Reactions to metals Latex or rubber dam

Foods

Heart Disease

Thyroid Problem

Local anesthetics (Novocaine) Penicillin or other antibiotics

Additional questions for women.

Are you pregnant or trying to get pregnant?

Creutzfeldt-Jakob disease (CJD)

High Blood Pressure

File No: 29114 J/ CO \ Nationality: | Newspapers Others Certain medical conditions can affect dental treatment and vice versa. Yes No Others, Please Specify occasional Rheumatic Fever Fainting / Seizures Leukemia Liver Disease Lung Disease Tuberculosis Hepatitis/Jaundice AIDS/HIV Infection Others, Please Specify Yes Others, Please Specify Yes Others, Please Specify

if yes, expected delivery date: Are you taking oral contraceptives? PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY 10 NO HURT **HURTS HURTS HURTS HURTS HURTS** LITTLE BIT LITTLE MORE **EVEN MORE** WHOLE LOT WORST No Pain Moderate Pain Worst Pain 8 10