

Name:

Date of Birth:

Chief Complaint: .

Are you a smoker?

Asthma

Stroke

Asperin or Ibuprofen Reactions to metals Latex or rubber dam

Foods

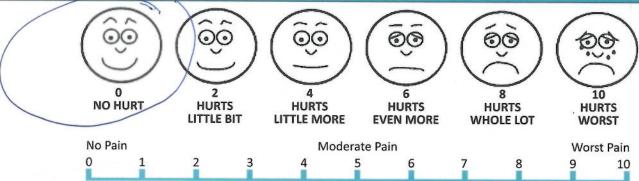
Heart Disease

Thyroid Problem

High Blood Pressure

File No: BOUT Ruchir Shah Mobile no.: +1-401-965-2498 Email: ruchic 12@ gmail. won Sex: O F Nationality: How do you know about us? Family or Friends ○ Internet Others Newspapers **MEDICAL HISTORY** Certain medical conditions can affect dental treatment and vice versa. Please complete this form by answering the questions. 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? Do you have, or have you had any of the following Low Blood Pressure Rheumatic Fever Fainting / Seizures **Epilepsy** Heart Attack Leukemia Kidney Disease Liver Disease Lung Disease Diabetes **Tuberculosis** Hepatitis/Jaundice 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: No Others, Please Specify Local anesthetics (Novocaine) Penicillin or other antibiotics 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



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.