

File No: 3062

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Name: Betrary Xible - while	. 1 /	\sim	
Mobile no.: 0589411882 Email: pethanyhibbenne e gnail com			
Date of Birth: 18/07/94 Sex: OM OF	Nati	onality: Rr	itish
How do you know about us?		ewspapers	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 C	Others, Please Specify
Are you under a physician's care now?			
Are you taking any medications, pills, or drugs?		1/	
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 Feve	er	○ Fa	ainting / Seizures
Asthma Heart Attack Epilepsy		O Le	eukemia
○ Heart Disease ○ Kidney Disease ○ Liver Disease		O Li	ung Disease
○ Thyroid Problem ○ Diabetes ○ Tuberculosis			epatitis/Jaundice
Stroke Arthritis Cancer			IDS/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)		1//	•
Penicillin or other antibiotics			
Asperin or Ibuprofen		1//	
Reactions to metals		///	
Latex or rubber dam		//	
Foods		1	
Additional questions for women.	Yes	No C	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 C	URREN	T PAIN INTENS	TY
NO Pain OOO A HURTS HURTS HURTS LITTLE BIT Moderate Pain	H	B URTS OLE LOT	10 HURTS WORST Worst Pain
0 1 2 3 4 5 6	7	8 0	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 tealth, I will inform the doctor at the next appointment without fail.