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MEDICAL HISTORY Sertain medical conditions can affect dental treatment and vice versa. Please complete this form by answering the questions. Inief Complaint: It details will be strictly confidential. Are you under a physician's care now? Are you taking any medications, pills, or drugs? Idave you ever been hospitalized or had a major operation? Idave you ever had any complications following dental treatment? Idave you a smoker? Idave you have, or have you had any of the following High Blood Pressure Asthma Heart Attack Epilepsy Heart Disease Thyroid Problem Diabetes Tuberculosis Stroke Arthritis Cancer Creutzfeldt–Jakob disease (CJD) Others, Please Specify— Ire you allergic, or have you reacted adversely to any of the following: Yes ocal anesthetics (Novocaine) enricillin or other antibiotics sperin or Ibuprofen eactions to metals atex or rubber dam oods dditional questions for women. re you pregnant or trying to get pregnant? yes, expected delivery date:		Pakistan
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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.