



Name: Sarah Abdel Aly

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Date of Birth: 1/9/1989 Sex: M F Nationality: Egyptian

How do you know about us? Family or Friends 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?		<input checked="" type="checkbox"/>	
Are you taking any medications, pills, or drugs?		<input checked="" type="checkbox"/>	
Have you ever been hospitalized or had a major operation?		<input checked="" type="checkbox"/>	
Have you ever had any complications following dental treatment?		<input checked="" type="checkbox"/>	
Are you a smoker?			

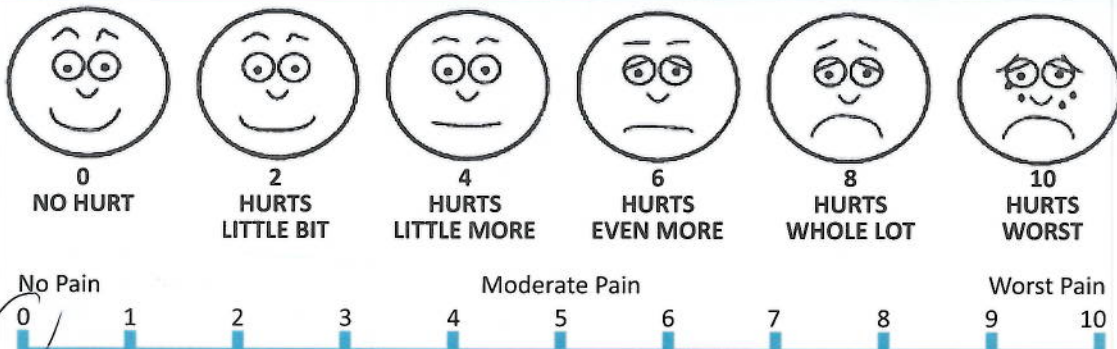
Do you have, or have you had any of the following

<input checked="" type="checkbox"/> High Blood Pressure	<input checked="" type="checkbox"/> Low Blood Pressure	<input checked="" type="checkbox"/> Rheumatic Fever	<input checked="" type="checkbox"/> Fainting / Seizures
<input checked="" type="checkbox"/> Asthma	<input checked="" type="checkbox"/> Heart Attack	<input checked="" type="checkbox"/> Epilepsy	<input checked="" type="checkbox"/> Leukemia
<input checked="" type="checkbox"/> Heart Disease	<input checked="" type="checkbox"/> Kidney Disease	<input checked="" type="checkbox"/> Liver Disease	<input checked="" type="checkbox"/> Lung Disease
<input checked="" type="checkbox"/> Thyroid Problem	<input checked="" type="checkbox"/> Diabetes	<input checked="" type="checkbox"/> Tuberculosis	<input checked="" type="checkbox"/> Hepatitis/Jaundice
<input checked="" type="checkbox"/> Stroke	<input checked="" type="checkbox"/> Arthritis	<input checked="" type="checkbox"/> Cancer	<input checked="" type="checkbox"/> AIDS/HIV Infection
<input checked="" type="checkbox"/> Creutzfeldt-Jakob disease (CJD)	<input checked="" type="checkbox"/> Others, Please Specify _____		

Are you allergic, or have you reacted adversely to any of the following:	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)		<input checked="" type="checkbox"/>	
Penicillin or other antibiotics		<input checked="" type="checkbox"/>	
Asperin or Ibuprofen		<input checked="" type="checkbox"/>	
Reactions to metals		<input checked="" type="checkbox"/>	
Latex or rubber dam		<input checked="" type="checkbox"/>	
Foods		<input checked="" type="checkbox"/>	

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.