

File No:

Name: Adam Belouat			
Mobile no.: 50 9 63 0 5 9 3 Email:			
Date of Birth: 25/09/2009 Sex: SM OF	Nationality: France		
How do you know about us?	O Ne	ewspap	
MEDICAL HISTORY			
Certain medical conditions can affect dental treatment and vice ve	ersa.		
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?		/	
Are you taking any medications, pills, or drugs?	200000	1	
Have you ever been hospitalized or had a major operation?	1		
Have you ever had any complications following dental treatment?		1	
Are you a smoker?		1	
Do you have, or have you had any of the following			
○ High Blood Pressure ○ Low Blood Pressure ○ Rheumatic Feve	r		Fainting / Seizures
Asthma Heart Attack Epilepsy	Leukemia		
○ Heart Disease ○ Kidney Disease ○ Liver Disease	Lung Disease		
○ Thyroid Problem ○ Diabetes ○ Tuberculosis	Hepatitis/Jaundice		
○ Stroke ○ 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:	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)		1	
Penicillin or other antibiotics		/	
Asperin or Ibuprofen		1	
Reactions to metals		1	
Latex or rubber dam		1	
Foods		1	
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 CL	URREN'	T PAIN I	NTENSITY
NO Pain OOO A HURTS LITTLE BIT Moderate Pain		8 JRTS DLE LOT	10 HURTS WORST Worst Pain
0 1 2 3 4 5 6	7	8	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 health, I will inform the doctor at the next appointment without fail.