



File No:

3017

Name: Pakhi Pahuja

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Date of Birth: 30/04/1983 Sex: M F Nationality:

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: Deep Bite

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?			<u>25 Seva</u>
Have you ever been hospitalized or had a major operation?			<u>C. Section 2020</u>
Have you ever had any complications following dental treatment?		<input checked="" type="checkbox"/>	
Are you a smoker?	<input checked="" type="checkbox"/>		<u>occasional</u>

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

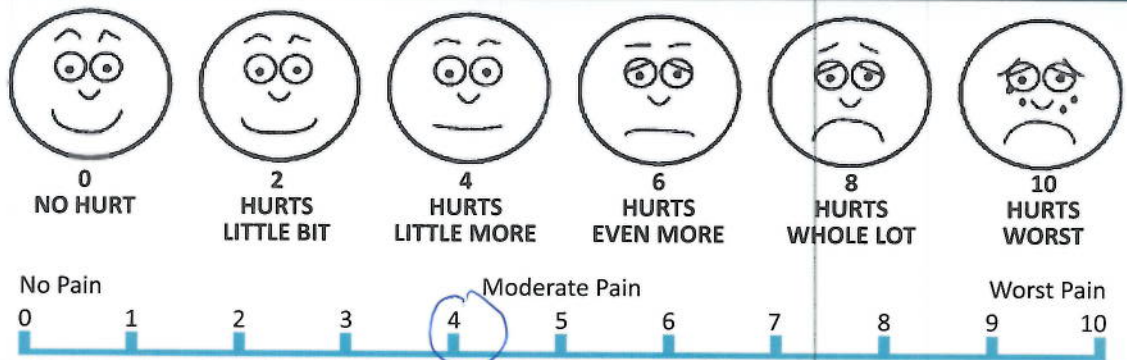
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Fainting / Seizures
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Thyroid Problem	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hepatitis/Jaundice
<input type="checkbox"/> Stroke	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> AIDS/HIV Infection
<input type="checkbox"/> Creutzfeldt-Jakob disease (CJD)	<input type="checkbox"/> Others, Please Specify <u>None</u>		

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"/>		<u>dairy (Fresh cheese)</u>

Additional questions for women.

Additional questions for women.	Yes	No	Others, Please Specify
Are you pregnant or trying to get pregnant?		<input checked="" type="checkbox"/>	
if yes, expected delivery date: _____		<input type="checkbox"/>	
Are you taking oral contraceptives?		<input checked="" type="checkbox"/>	

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.