DENTISTREE DENTAL CLINIC

File No: 3629

Name:	Eran Cohen		
Mobile no.:	058- 5599518	Email:	
Date of Birth:	9/8/77	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: _____

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?			Lipitor
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 Fever	○ 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	N/A

Are you allergic, or have you reacted adversely to any of the following:	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)		✓	
Penicillin or other antibiotics		✓	
Asperin or Ibuprofen		✓	
Reactions to metals		✓	
Latex or rubber dam		✓	
Foods		✓	

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.