



File No:

4001

Name: Afraa Alidrisi

Mobile no.: 0523737389 Email: alsharifaz3@gmail.com

Date of Birth: 8 Dec 1985 Sex: M F Nationality: Saudi

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"/> | | <u>High Nairoly 50g</u> |
| Have you ever been hospitalized or had a major operation? | <input checked="" type="checkbox"/> | | <u>Cesarian</u> |
| Have you ever had any complications following dental treatment? | | <input checked="" type="checkbox"/> | |
| Are you a smoker? | | <input checked="" type="checkbox"/> | |

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 _____ | | |

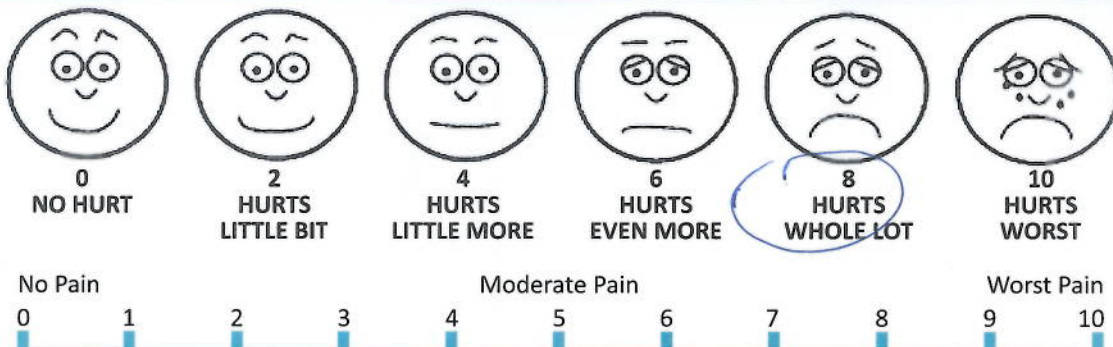
Are you allergic, or have you reacted adversely to any of the following:

| | Yes | No | Others, Please Specify |
|---------------------------------|-------------------------------------|----|------------------------|
| Local anesthetics (Novocaine) | | | |
| Penicillin or other antibiotics | | | |
| Asperin or Ibuprofen | | | |
| Reactions to metals | | | |
| Latex or rubber dam | | | |
| Foods | <input checked="" type="checkbox"/> | | <u>Peanuts</u> |

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: _____ | | | |
| 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.