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File No:

Uganda

Name: *Marabito Janizer*

Mobile no.: *0759707716* Email:

Date of Birth: *11/12/1981* Sex: M F Nationality: *uganda*

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?	<i>Atx</i>	<input checked="" type="checkbox"/>	
Are you a smoker?		<input checked="" type="checkbox"/>	

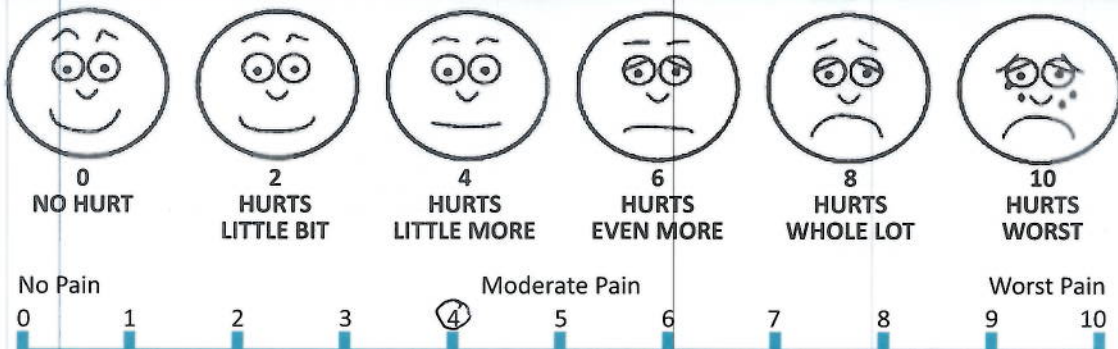
Do you have, or have you had any of the following

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 _____

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?		<input checked="" type="checkbox"/>	
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.