



Name: **EMAN SIDDIQUI**

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Email: **86 - eman@gmail.com**

Date of Birth: **31/12/1986**

Sex:  M  F

Nationality: **INDIAN**

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"/>		<b>Multivitamins.</b>
Have you ever been hospitalized or had a major operation?		<input checked="" type="checkbox"/>	
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="radio"/> High Blood Pressure	<input type="radio"/> Low Blood Pressure	<input type="radio"/> Rheumatic Fever	<input type="radio"/> Fainting / Seizures
<input checked="" type="checkbox"/> Asthma	<input type="radio"/> Heart Attack	<input type="radio"/> Epilepsy	<input type="radio"/> Leukemia
<input type="radio"/> Heart Disease	<input type="radio"/> Kidney Disease	<input type="radio"/> Liver Disease	<input type="radio"/> Lung Disease
<input type="radio"/> Thyroid Problem	<input type="radio"/> Diabetes	<input type="radio"/> Tuberculosis	<input type="radio"/> Hepatitis/Jaundice
<input type="radio"/> Stroke	<input type="radio"/> Arthritis	<input type="radio"/> Cancer	<input type="radio"/> AIDS/HIV Infection
<input type="radio"/> Creutzfeldt-Jakob disease (CJD)		<input type="radio"/> Others, Please Specify	

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

Local anesthetics (Novocaine)	Yes	No	Others, Please Specify
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"/>	

Additional questions for women.

Are you pregnant or trying to get pregnant?

if yes, expected delivery date: 1st July 2025

Are you taking oral contraceptives?

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY



**0**

**NO HURT**



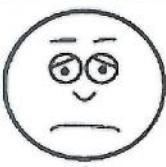
**2**

**HURTS LITTLE BIT**



**4**

**HURTS LITTLE MORE**



**6**

**HURTS EVEN MORE**



**8**

**HURTS WHOLE LOT**



**10**

**HURTS WORST**

No Pain

**0**

**1**

**2**

**3**

Moderate Pain

**4**

**5**

**6**

**7**

**8**

Worst Pain

**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.