

Name: Ivanna Menezes				
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Date of Birth:	31-12-1997	Sex:	<input type="radio"/> M	<input checked="" type="radio"/> F
How do you know about us?		<input checked="" type="radio"/> Family or Friends	<input type="radio"/> Internet	<input type="radio"/> Newspapers
		<input type="radio"/> 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"/>		ZURTEC
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 **N/A**

<input type="radio"/> High Blood Pressure	<input type="radio"/> Low Blood Pressure	<input type="radio"/> Rheumatic Fever	<input type="radio"/> Fainting / Seizures
<input type="radio"/> 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 N/A			

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

Yes	No	Others, Please Specify
	<input checked="" type="checkbox"/>	

Additional questions for women.

Yes	No	Others, Please Specify
	<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.