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Date of Birth: 14-08-2000	Sex: <input checked="" type="radio"/> M <input type="radio"/> F Nationality: INDIAN
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?		/	
Are you taking any medications, pills, or drugs?		/	
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

<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	

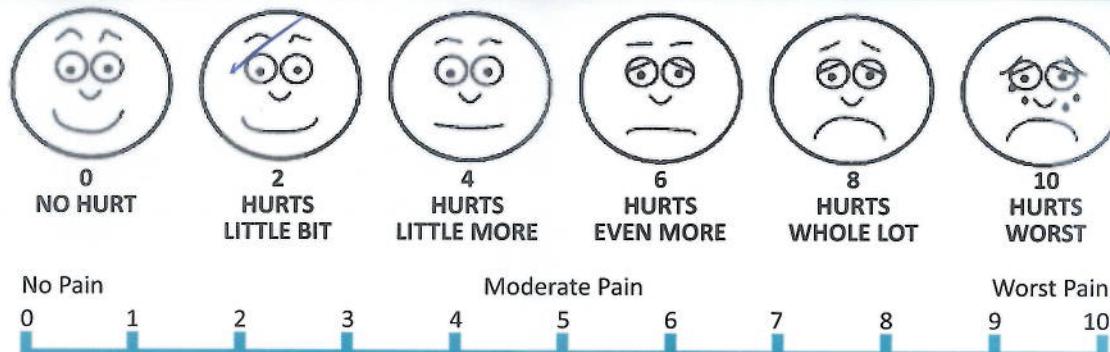
Are you allergic, or have you reacted adversely to any of the following:

Local anesthetics (Novocaine)	/
Penicillin or other antibiotics	/
Asperin or Ibuprofen	/
Reactions to metals	/
Latex or rubber dam	/
Foods	/

Additional questions for women.

Are you pregnant or trying to get pregnant?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
if yes, expected delivery date:		
Are you taking oral contraceptives?	<input type="checkbox"/>	<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.