



# DENTISTREE DENTAL CLINIC

File no: 527

Name: <u>MUNIZA BADAR</u>			
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Date of Birth: <u>01/05/1992</u>	Sex: <input type="radio"/> M <input checked="" type="radio"/> F	Nationality: <u>PAKISTANI</u>	
How do you know about us? <input type="radio"/> Family or Friends <input type="radio"/> Internet <input type="radio"/> Newspapers <input checked="" 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"/>		
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="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 <u>NONE</u>		

Are you allergic, or have you reacted adversely to any of the following:	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)		<input checked="" type="checkbox"/>	
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.	Yes	No	Others, Please Specify
Are you pregnant or trying to get pregnant?	<input checked="" type="checkbox"/>		
if yes, expected delivery date: <u>15<sup>th</sup> July</u>			
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.**

Signature of Patient, Parent or Guardian: Muniza      Date: 10/2/2022