DENTISTREE DENTAL CLINIC

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File no:

Name: Mita H. Shah			
Mobile no.: 091 9998002865	**Email:**		
Date of Birth: 25-05-1969	**Sex:** o M o F ✓	**Nationality:** Indian	
How do you know about us? ✓ Family or Friends	o Internet	o Newspapers	o 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?			

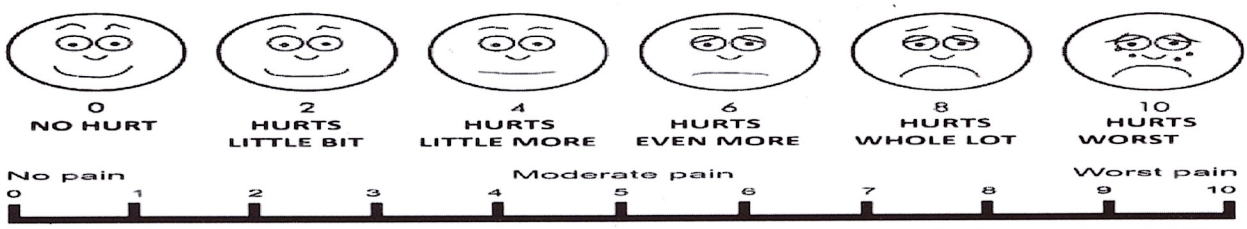
Do you have, or have you had any of the following

◯ 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?			
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.

Signature of Patient, Parent or Guardian Date