



DENTISTREE DENTAL CLINIC

File no: _____

| | | | |
|---|---|--------------------------------|--|
| Name: <u>Karis Manucha</u> | | | |
| Mobile no.: <u>0544045035</u> | Email: _____ | | |
| Date of Birth: <u>08 March 1988</u> | Sex: <input type="radio"/> M <input checked="" type="radio"/> F | Nationality: <u>Indonesian</u> | |
| How do you know about us? <input checked="" type="checkbox"/> Family or Friends <input type="checkbox"/> Internet <input type="checkbox"/> Newspapers <input type="checkbox"/> Others | | | |

Medical History

Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

Chief Complaint: general check up

| 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"/> | |

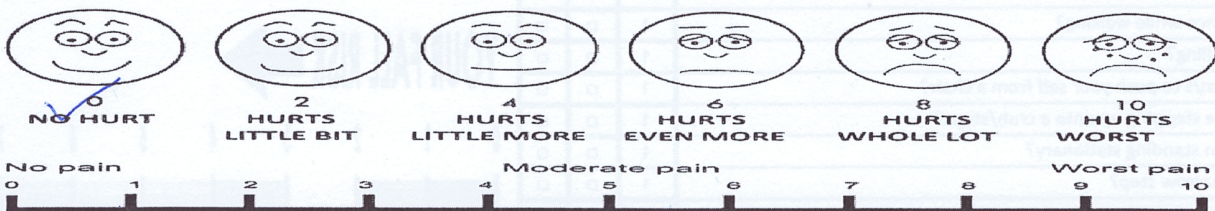
Do you have, or have you had any of the following

- | | | | |
|--|---|--|--|
| <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 _____ | | |

| 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: _____ | | | |
| 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 [Signature]

Date _____