DENTISTREE DENTAL CLINIC

Done

File no: 621

Name: RAJVI MADHVANI			
Mobile no.: 050 4665176	Email: rajvi79@gmail.com		
Date of Birth: 06/08/1979	Sex: o M ~~o F~~	Nationality:	
How do you know about us? o ~~Family or Friends~~	o Internet	o Newspapers	o Others Dr Aditi

Medical History

Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

Chief Complaint: crowns

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?	✓		Thyroxine 100mg.
Have you ever had any complications following dental treatment?	✓		Root canal.
Are you a smoker?		✓	

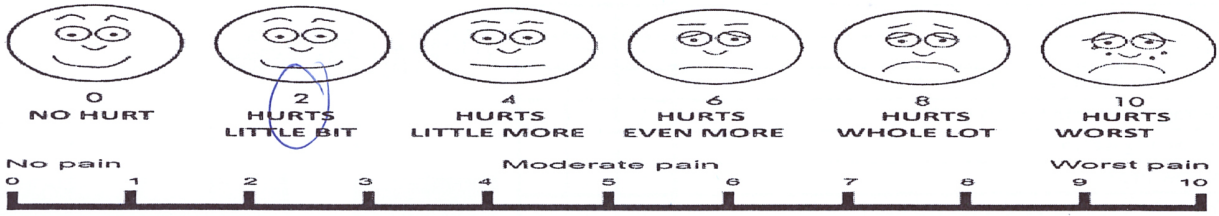
Do you have, or have you had any of the following

○ 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 Thyroid		

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	✓	~~✓~~	acidic/bloating
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

15/03/2022.
Date