DENTISTREE DENTAL CLINIC

Done

File no: 623

Name: Richard Young			
Mobile no.: 058 651 7094	Email: lredaway@gmail.com		
Date of Birth: 1st Sept 85	Sex: ✓M o F	Nationality: South African	
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?		✓	

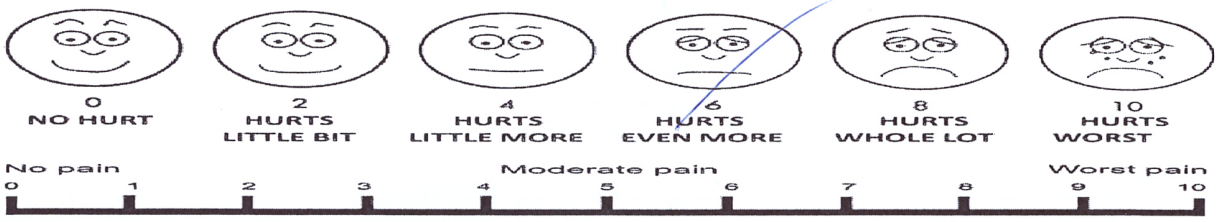
Do you have, or have you had any of the following

◯ 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

15.03.21
Date