



# DENTISTREE DENTAL CLINIC

Done

File no: 634

Name: BANI CHUGH

Mobile no.: 0502974772 Email: chughbani@gmail.com

Date of Birth: 11/11/1988 Sex:  M  F Nationality: INDIAN

How do you know about us?  Family or Friends  Internet  Newspapers  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"/>	

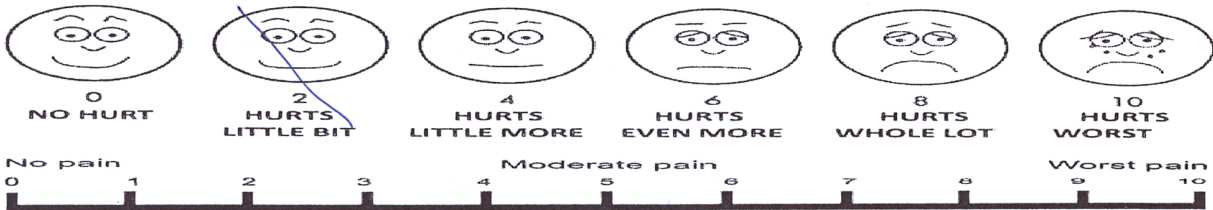
### Do you have, or have you had any of the following

- 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)		<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?			

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: Bani Chugh

Date: 21.03.22