

Signature of Patient, Parent or Guardian

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File no:	677	

Name: Sind Raiwk unas Shah			
Name: Siya Rajwk unas Shah Mobile no.: 055 9194116 Email:			
Date of Birth: 22-05-2010 Sex: OM 0F	Natio	nality:	U K
How do you know about us? o Family or Friends o Internet o News	spapers	5	o Others
Medical History			
		V)-	
Certain medical conditions can affect dental treatment and v	/ice v	ersa.	
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?	Τ.	ſ.	
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 Fe	ver		Fainting / Seizures
Asthma Heart Attack Epilepsy			C Leukemia
Heart Disease			O Lung Disease
Thyroid Problem Diabetes Tuberculosis			Hepatitis/Jaundice
Stroke Arthritis Cancer			AIDS/HIV Infection
	Specif		<u> </u>
Credizielai–Jakob disease (CJD) Uniers, Please	: Specii	V	
	A STATE OF THE PARTY OF THE PAR		Others, Please Specify
Are you allergic, or have you reacted adversely to any of the following:	Yes	No	Others, Please Specify
	A STATE OF THE PARTY OF THE PAR		Others, Please Specify
Are you allergic, or have you reacted adversely to any of the following: Local anesthetics (Novocaine)	A STATE OF THE PARTY OF THE PAR		Others, Please Specify
Are you allergic, or have you reacted adversely to any of the following: Local anesthetics (Novocaine) Penicillin or other antibiotics	A STATE OF THE PARTY OF THE PAR		Others, Please Specify
Are you allergic, or have you reacted adversely to any of the following: Local anesthetics (Novocaine) Penicillin or other antibiotics Asperin or Ibuprofen	A STATE OF THE PARTY OF THE PAR		Others, Please Specify
Are you allergic, or have you reacted adversely to any of the following: Local anesthetics (Novocaine) Penicillin or other antibiotics Asperin or Ibuprofen Reactions to metals	A STATE OF THE PARTY OF THE PAR		Others, Please Specify
Are you allergic, or have you reacted adversely to any of the following: Local anesthetics (Novocaine) Penicillin or other antibiotics Asperin or Ibuprofen Reactions to metals Latex or rubber dam Foods	Yes	No	
Are you allergic, or have you reacted adversely to any of the following: Local anesthetics (Novocaine) Penicillin or other antibiotics Asperin or Ibuprofen Reactions to metals Latex or rubber dam Foods Additional questions for women.	A STATE OF THE PARTY OF THE PAR		Others, Please Specify Others, Please Specify
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Date