DENTISTREE DENTAL CLINIC

File no: 774

Name: Ronald Fischer		
Mobile no.: 050 8289014	Email: ronaldfischer1980@gmail.com	
Date of Birth: 3.8.1980	Sex: ~~o~~ M o F	Nationality: German
How do you know about us? ~~o~~ 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?		X	
Are you taking any medications, pills, or drugs?		X	
Have you ever been hospitalized or had a major operation?	X		Sinusas
Have you ever had any complications following dental treatment?		X	
Are you a smoker?		X	

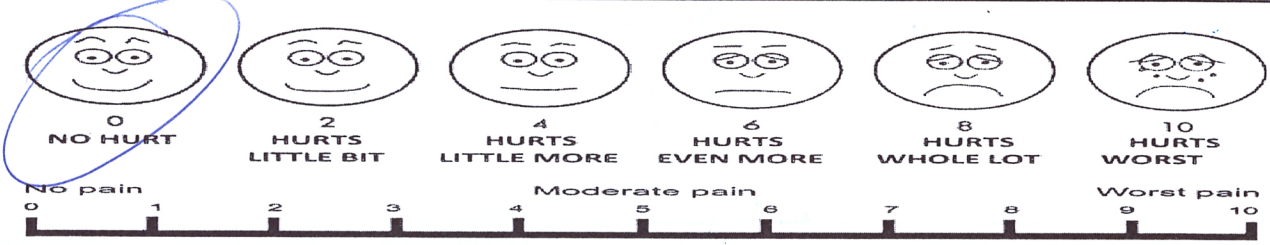
Do you have, or have you had any of the following

◯ 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)		X	
Penicillin or other antibiotics		X	
Asperin or Ibuprofen		X	
Reactions to metals		X	
Latex or rubber dam		X	
Foods		X	

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.

X _____ 7.5.22

Signature of Patient, Parent or Guardian Date