

File No: 1768

Name: Ivan Serynh			District Control	
Mobile no.: + 7908 4581512 Email: xxx Jackxxx 2003	9@ me	uil.re	4	
Date of Birth: 18. 10. 7996 Sex: 5 M OF	Natio	Nationality: Russian		
How do you know about us?	○ Ne	wspape	rs Others	
MEDICAL HISTORY	MARK.	1	N THE BUILD	
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?	1.02	V	- Canada openny	
Are you taking any medications, pills, or drugs?	-	V		
Have you ever been hospitalized or had a major operation?	1	V	***************************************	
Have you ever had any complications following dental treatment?		V		
Are you a smoker?		V		
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 ○ Kidney Disease ○ Liver Disease	C Lung Disease			
○ Thyroid Problem ○ Diabetes ○ Tuberculosis		(Hepatitis/Jaundice	
○ Stroke ○ Arthritis ○ Cancer		(AIDS/HIV Infection	
Creutzfeldt–Jakob disease (CJD) Others, Please	e Specify_			
Are you allergic, or have you reacted adversely to any of the following:	Yes	No	Others, Please Specify	
Local anesthetics (Novocaine)		V		
Penicillin or other antibiotics		V		
Asperin or Ibuprofen		V		
Reactions to metals		V		
Latex or rubber dam		0		
Foods		V	-19-10-00-0	
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 IN	ITENSITY	
No Hurt Hurts Hurts Hurts Hurts Even More		8 JRTS DLE LOT	10 HURTS WORST	
No Pain Moderate Pain 0 1 2 3 4 5 6	7	8	Worst Pain 9 10	