



File No:

2844

Name: FIKILE NKHWASHU

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Date of Birth: 1997-08-22 Sex:  M  F Nationality:

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?		X	
Are you taking any medications, pills, or drugs?		X	
Have you ever been hospitalized or had a major operation?		X	
Have you ever had any complications following dental treatment?		X	
Are you a smoker?	X		

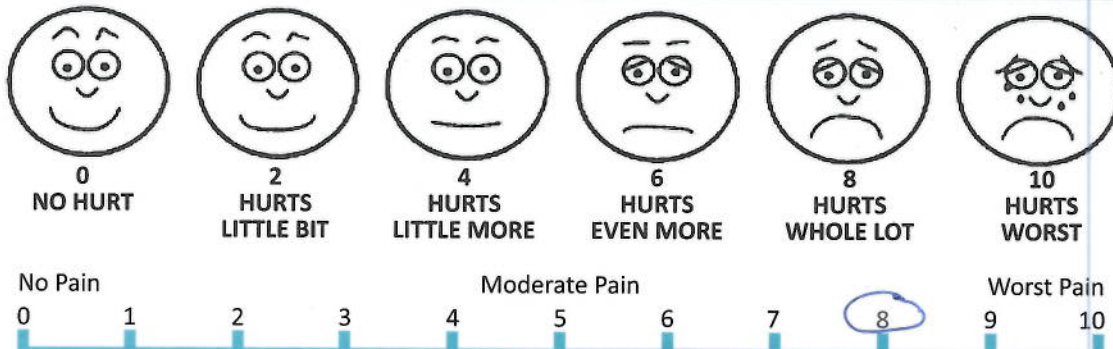
Do you have, or have you had any of the following

- 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?		X	
if yes, expected delivery date: _____			
Are you taking oral contraceptives?		X	

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.