



File No:

312

Name: *Sophia Schools*  
 Mobile no.: *404 690 4385* Email: *fschoolsophia fschoolsophia@gmail.com*  
 Date of Birth: *03/16/2003* 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?		<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**

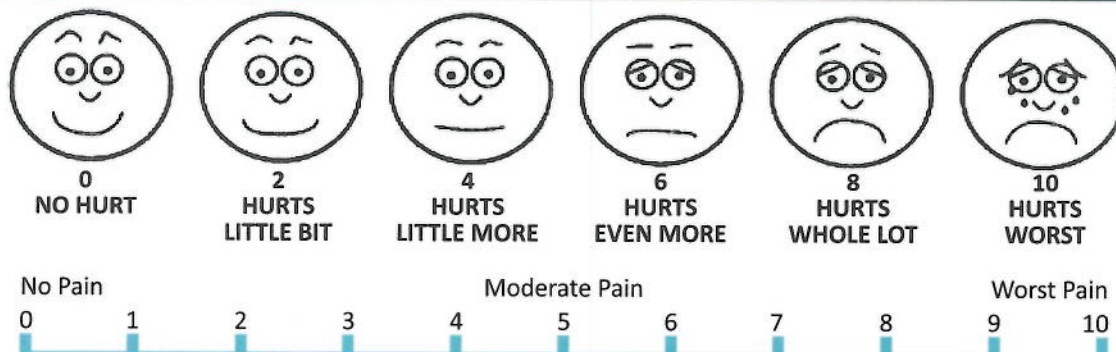
<input type="radio"/> High Blood Pressure	<input type="radio"/> Low Blood Pressure	<input type="radio"/> Rheumatic Fever	<input type="radio"/> Fainting / Seizures
<input type="radio"/> Asthma	<input type="radio"/> Heart Attack	<input type="radio"/> Epilepsy	<input type="radio"/> Leukemia
<input type="radio"/> Heart Disease	<input type="radio"/> Kidney Disease	<input type="radio"/> Liver Disease	<input type="radio"/> Lung Disease
<input type="radio"/> Thyroid Problem	<input type="radio"/> Diabetes	<input type="radio"/> Tuberculosis	<input type="radio"/> Hepatitis/Jaundice
<input type="radio"/> Stroke	<input type="radio"/> Arthritis	<input type="radio"/> Cancer	<input type="radio"/> AIDS/HIV Infection
<input type="radio"/> Creutzfeldt-Jakob disease (CJD)	<input type="radio"/> 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.**

Are you pregnant or trying to get pregnant?	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? <i>Yes - June 1st</i>			

**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.