

File No: 3349

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Name: Drishya Nair			
Mobile no.: 055-4895642 Email: drish	rais a gman	1 60	m.
Date of Birth: 25/06/1999 Sex: OM		onality:	
	nternet ON	ewspap	ers Others
MEDICAL HIS	STORY		
Certain medical conditions can affect dental treatment			
Please complete this form by answering the questions.			
Chief Complaint:			
All details will be strictly confidential.	Vas	M-	Oahana Blassa Cusaifu
	Yes	No	Others, Please Specify
Are you under a physician's care now?			
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			Fainting / Seizures
Asthma Heart Attack Epilepsy			Leukemia
Heart Disease Cidney Disease Liv	er Disease		Lung Disease
Thyroid Problem Diabetes Tul	perculosis		Hepatitis/Jaundice
Stroke Arthritis Car	ncer		AIDS/HIV Infection
Creutzfeldt–Jakob disease (CJD)	ners, Please Specify	/	Vo
Are you allergic, or have you reacted adversely to any of the following:	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)		/	
Penicillin or other antibiotics		/	
Asperin or Ibuprofen			
Reactions to metals		1	
Latex or rubber dam			
Foods			
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 REPRES	ENTS YOUR CURREN	T PAIN I	INTENSITY
PLEASE SELECT THE NUMBER THAT BEST REPRESI	(a)	T PAIN I	NTENSITY 10 HURTS
		OKIS	
No Pain Moderate Pa	in		Worst Pain
0 1 2 3 4 5	6 7	8	9 10

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.