



File No:

347

Name: Arkwaizee, Mustafa

Mobile no.: _____ Email: Mostafaarkwaizee91@gmail.com

Date of Birth: 01.01.1991 Sex: M F Nationality: Iraq

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?		/	
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 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)		/	
Penicillin or other antibiotics		/	
Asperin or Ibuprofen		/	
Reactions to metals		/	
Latex or rubber dam		/	
Foods		/	

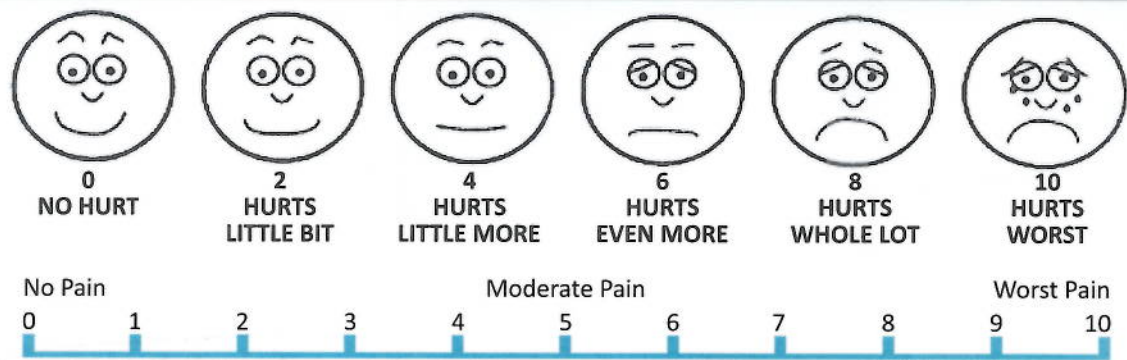
Additional questions for women.

Are you pregnant or trying to get pregnant? Yes No

if yes, expected delivery date: _____

Are you taking oral contraceptives? Yes No

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.