



File No:

3011

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Date of Birth: <u>30/11/1986</u>	Sex: <input type="radio"/> M <input checked="" type="radio"/> F	Nationality: <u>Egypt</u>	
How do you know about us? <input type="radio"/> Family or Friends <input type="radio"/> Internet <input type="radio"/> Newspapers <input checked="" type="radio"/> Others <u>google</u>			

## 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?		<u>-</u>	
Are you taking any medications, pills, or drugs?		<u>-</u>	
Have you ever been hospitalized or had a major operation?		<u>-</u>	
Have you ever had any complications following dental treatment?		<u>-</u>	
Are you a smoker?		<u>-</u>	

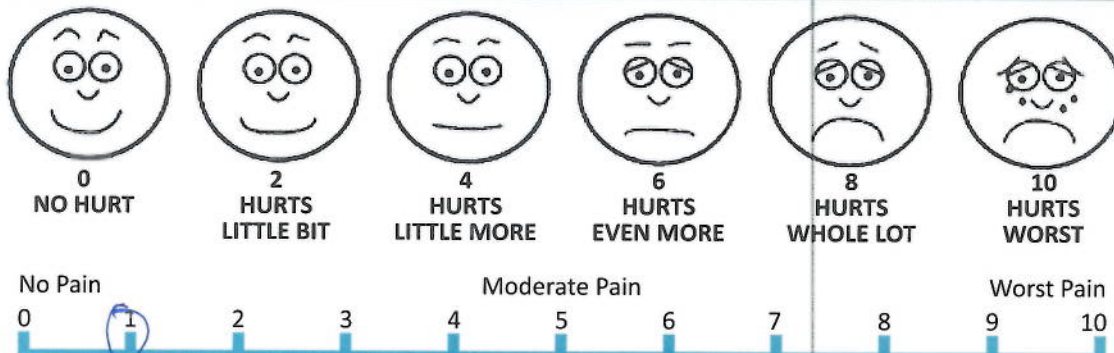
Do you have, or have you had any of the following

- |   |  |                                       |   |
|---|--|---------------------------------------|---|
| <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)		<u>-</u>	
Penicillin or other antibiotics		<u>-</u>	
Asperin or Ibuprofen		<u>-</u>	
Reactions to metals		<u>-</u>	
Latex or rubber dam		<u>-</u>	
Foods		<u>-</u>	

Additional questions for women.	Yes	No	Others, Please Specify
Are you pregnant or trying to get pregnant?		<u>-</u>	
if yes, expected delivery date: _____			
Are you taking oral contraceptives?			

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.