



File No:

3997

Name: <u>Safora Anwar</u>			
Mobile no.: <u>056 6206381</u>	Email: _____		
Date of Birth: <u>10/06/1994</u>	Sex: <input type="radio"/> M <input checked="" type="radio"/> F	Nationality: <u>Pakistani</u>	
How do you know about us? <input type="radio"/> Family or Friends <input type="radio"/> Internet <input type="radio"/> Newspapers <input type="radio"/> 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?			<u>Vit-D</u>
Have you ever been hospitalized or had a major operation?		<input checked="" type="checkbox"/>	
Have you ever had any complications following dental treatment?			<u>never done</u>
Are you a smoker?		<input checked="" type="checkbox"/>	

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

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Low Blood Pressure               | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting / Seizures |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Heart Attack                     | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Leukemia            |
| <input type="checkbox"/> Heart Disease                   | <input type="checkbox"/> Kidney Disease                   | <input type="checkbox"/> Liver Disease   | <input type="checkbox"/> Lung Disease        |
| <input type="checkbox"/> Thyroid Problem                 | <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Hepatitis/Jaundice  |
| <input type="checkbox"/> Stroke                          | <input type="checkbox"/> Arthritis                        | <input type="checkbox"/> Cancer          | <input type="checkbox"/> AIDS/HIV Infection  |
| <input type="checkbox"/> Creutzfeldt-Jakob disease (CJD) | <input type="checkbox"/> Others, Please Specify <u>NA</u> |  |  |

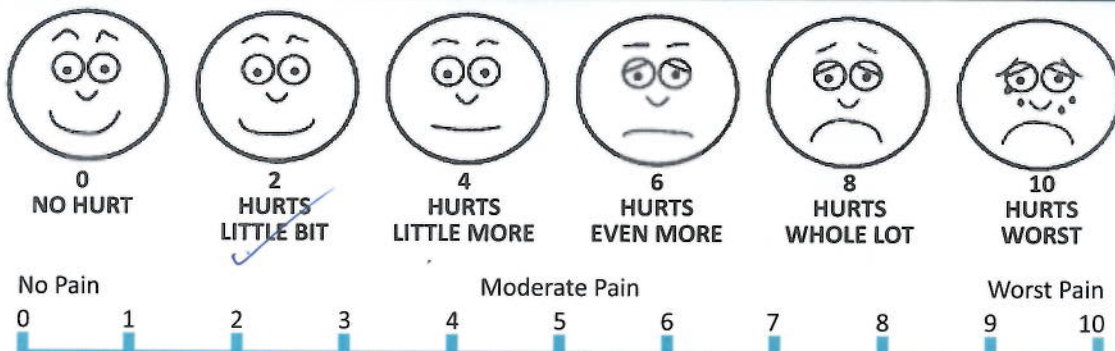
Are you allergic, or have you reacted adversely to any of the following:

	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)			
Penicillin or other antibiotics		<input checked="" type="checkbox"/>	
Asperin or Ibuprofen			
Reactions to metals			
Latex or rubber dam			
Foods			

Additional questions for women.

	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? <u>NA</u>			

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.