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Name: NAFTI

Mobile no.: 0556198994 Email: siham.b873@gmail.com

Date of Birth: 22/06/87 23/07/83 Sex: M F Nationality: FRANCE

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"/> | |

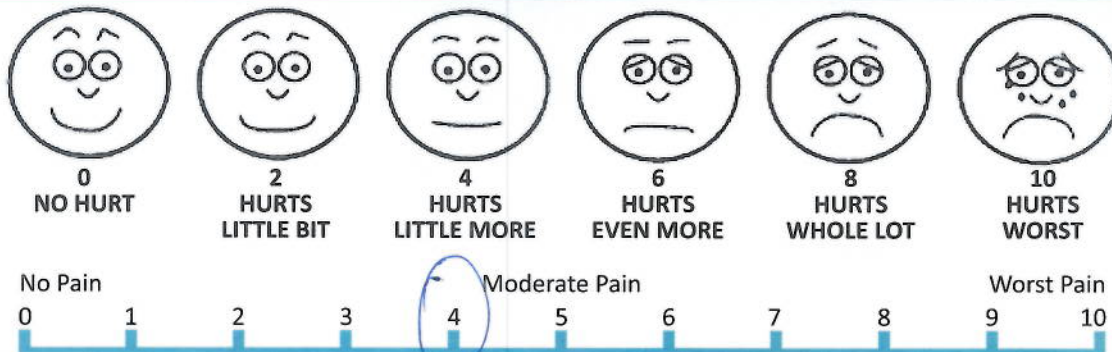
Do you have, or have you had any of the following

- 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) | | <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. | 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? | | <input checked="" type="checkbox"/> | |

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.