



# DENTISTREE DENTAL CLINIC

File No:

0065

Name:	Rajesh S. Menon		
Mobile no.:	050-6572736	Email:	stryline@eim.ae
Date of Birth:	5/1/59	Sex:	<input checked="" type="radio"/> M <input type="radio"/> F
		Nationality:	Indian
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			

## 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"/>	<input type="checkbox"/>	
Are you taking any medications, pills, or drugs?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Have you ever been hospitalized or had a major operation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Have you ever had any complications following dental treatment?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Are you a smoker?	<input type="checkbox"/>	<input type="checkbox"/>	

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 checked="" 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)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Penicillin or other antibiotics	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Asperin or Ibuprofen	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Reactions to metals	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Latex or rubber dam	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Foods	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

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

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY

0 NO HURT	2 HURTS LITTLE BIT	4 HURTS LITTLE MORE	6 HURTS EVEN MORE	8 HURTS WHOLE LOT	10 HURTS WORST
No Pain <span style="margin-left: 100px;">Moderate Pain</span> <span style="float: right;">Worst Pain</span>					
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.