

File No: 1793

Name: Parag Bookhey			
Mobile no.: 050 452182 Email: parag 2480 yahoo. com. sg.			
Date of Birth: 28/09/1970 Sex: O-M O F	Nationality:		
How do you know about us?	○ Ne	wspape	rs Others
MEDICAL HISTORY			
Certain medical conditions can affect dental treatment and vice ve	ersa.		
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?		1_	
Are you taking any medications, pills, or drugs?		-	
Have you ever been hospitalized or had a major operation?		1	
Have you ever had any complications following dental treatment?		~	
Are you a smoker?	2	-	
Do you have, or have you had any of the following			
○ High Blood Pressure ○ Low Blood Pressure ○ Rheumatic Feve	er	(	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 S	Specify_		
Are you allergic, or have you reacted adversely to any of the following:	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)		V.	
Penicillin or other antibiotics		V	
Asperin or Ibuprofen		~	
Reactions to metals		~	
Latex or rubber dam		-	56
Foods			
Additional questions for women.	Yes	No	Others, Please Specify
Are you pregnant or trying to get pregnant?			
if yes, expected delivery date:			
Are you taking oral contraceptives?	, s		
PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR C	URREN	T PAIN IN	ITENSITY
No Pain  No Pain		8 URTS DLE LOT	10 HURTS WORST  Worst Pain 9 10
0 1 2 3 4 5 6	_	0	9 10