



File No:

2496

|   |   |                            |  |
|---|---|----------------------------|--|
| Name: <u>Shashi Moya</u>  |   |                            |  |
| Mobile no.: <u>055280 5777</u>  | Email: <u>moyashashi13@gmail.com</u>                            |                            |  |
| Date of Birth: <u>13-05-1984</u>  | Sex: <input type="radio"/> M <input checked="" type="radio"/> F | Nationality: <u>Indian</u> |  |
| How do you know about us? <input checked="" 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: toothache

| 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

|  |   |  |  |
|--|---|--|--|
| <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 _____ |  |  |

| 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?         |     |                                     |                        |

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY

|              |                          |                           |                         |                         |                      |   |   |   |   |    |
|--------------|--------------------------|---------------------------|-------------------------|-------------------------|----------------------|---|---|---|---|----|
|              |                          |                           |                         |                         |                      |   |   |   |   |    |
| 0<br>NO HURT | 2<br>HURTS<br>LITTLE BIT | 4<br>HURTS<br>LITTLE MORE | 6<br>HURTS<br>EVEN MORE | 8<br>HURTS<br>WHOLE LOT | 10<br>HURTS<br>WORST |   |   |   |   |    |
| No Pain      | Moderate Pain            |                           |                         |                         | Worst Pain           |   |   |   |   |    |
| 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.