



File No: 254/

|   |   |                             |  |
|---|---|-----------------------------|--|
| Name: <u>Margarita</u>  |   |                             |  |
| Mobile no.: <u>0563030677</u>   | Email: <u>margarita.antonova@hotmail.com</u>                    |                             |  |
| Date of Birth: <u>3.6.1990</u>  | Sex: <input type="radio"/> M <input checked="" type="radio"/> F | Nationality: <u>Russian</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: \_\_\_\_\_

| All details will be strictly confidential.                      | Yes | No | Others, Please Specify |
|---|-----|----|------------------------|
| Are you under a physician's care now?                           |     | ✓  |                        |
| Are you taking any medications, pills, or drugs?                |     | ✓  |                        |
| Have you ever been hospitalized or had a major operation?       |     |    | 2 C-sections           |
| Have you ever had any complications following dental treatment? |     | ✓  |                        |
| Are you a smoker?   |     | ✓  |                        |

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

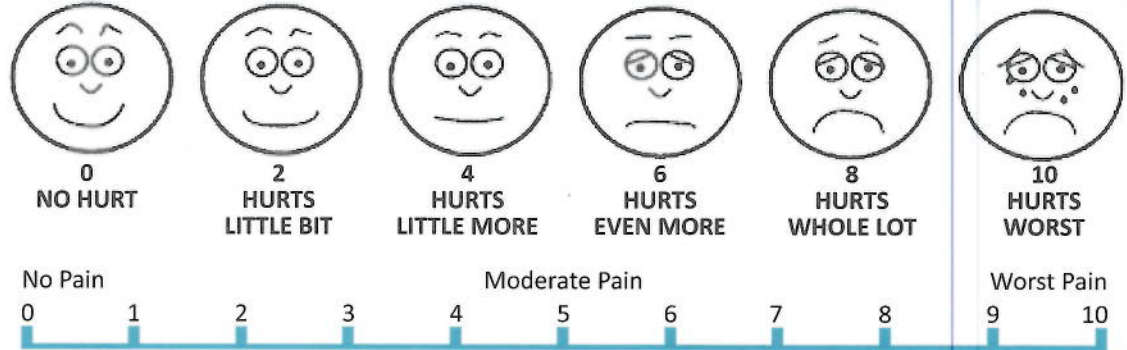
|   |  |                                       |   |
|---|--|---------------------------------------|---|
| <input type="radio"/> High Blood Pressure             | <input type="radio"/> Low Blood Pressure           | <input type="radio"/> Rheumatic Fever | <input type="radio"/> Fainting / Seizures |
| <input type="radio"/> Asthma                          | <input type="radio"/> Heart Attack                 | <input type="radio"/> Epilepsy        | <input type="radio"/> Leukemia            |
| <input 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)  |     | ✓  |                        |
| Penicillin or other antibiotics  |     | ✓  |                        |
| 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? |     | ✓  |                        |
| if yes, expected delivery date: _____       |     |    |                        |

Are you taking oral contraceptives? Yes, Yaz

### 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.