

File No: 2374

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Name: Simaan Ib	valin					
Mobile no.: 055 354 6 35		Simon. Ebrahi	ma	hotin	ail-com	
Date of Birth: 25 - 11 - 19		OM OF		onality:	Syria	
How do you know about us?	○ Family or Friends	○ Internet	O N	ewspape		
	MED	ICAL HISTORY	1			
Certain medical conditions	can affect dental tr	eatment and vice v	/ersa.			
Please complete this form by answ	ering the questions.				411	
Chief Complaint:						
All details will be strictly confiden	tial.		Yes	No	Others, Please Specify	
Are you under a physician's care now?				e		
Are you taking any medications, pills, or drugs?				_		
Have you ever been hospitalized or had a major operation?				(
Have you ever had any complications following dental treatment?				c		
Are you a smoker?				ı		
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				O Hepatitis/Jaundice		
O Stroke	Arthritis	Cancer		(AIDS/HIV Infection	
Creutzfeldt–Jakob disease (CJI))	Others, Please	Specify.			
Are you allergic, or have you reacted adversely to any of the following:			Yes	No	Others, Please Specify	
Local anesthetics (Novocaine)				e		
Penicillin or other antibiotics				C		
Asperin or Ibuprofen				c		
Reactions to metals				c		
Latex or rubber dam				0		
Foods				c		
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?						
PLEASE SEL	ECT THE NUMBER THAT B	EST REPRESENTS YOUR C	URREN	T PAIN IN	ITENSITY	
	DE LITTLE BIT	6 HURTS ORE EVEN MORE		8 JRTS DLE LOT	10 HURTS WORST	
No Pain	2 3 A	Noderate Pain	7	0	Worst Pain	