



File No:

2604

Name: SAFA NI2AM			
Mobile no.: 0502513110	Email:		
Date of Birth: 18/02/1995	Sex: <input type="radio"/> M <input checked="" 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: Gaining teeth.

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?	/		ASD closure.
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 checked="" 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 _____		

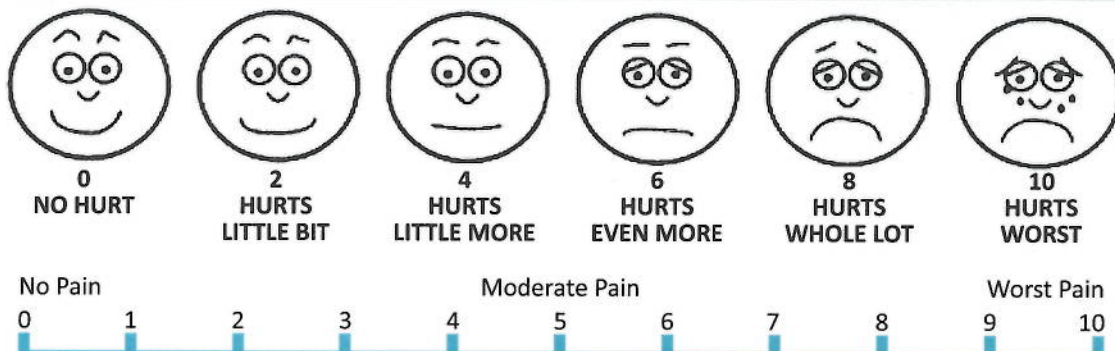
Are you allergic, or have you reacted adversely to any of the following:

	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?		/	

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.