



File No:

2974

Name: <u>Melissa Schneider</u>			
Mobile no.: <u>0581425421</u>	Email:		
Date of Birth: <u>19.2.91</u>	Sex: <input type="radio"/> M <input checked="" type="radio"/> F	Nationality: <u>Austrian</u>	
How do you know about us? <input type="radio"/> Family or Friends <input checked="" 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?	X		Dermatologist
Are you taking any medications, pills, or drugs?	X		Thyrex 75
Have you ever been hospitalized or had a major operation?		X	
Have you ever had any complications following dental treatment?		X	
Are you a smoker?		X	

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 _____		

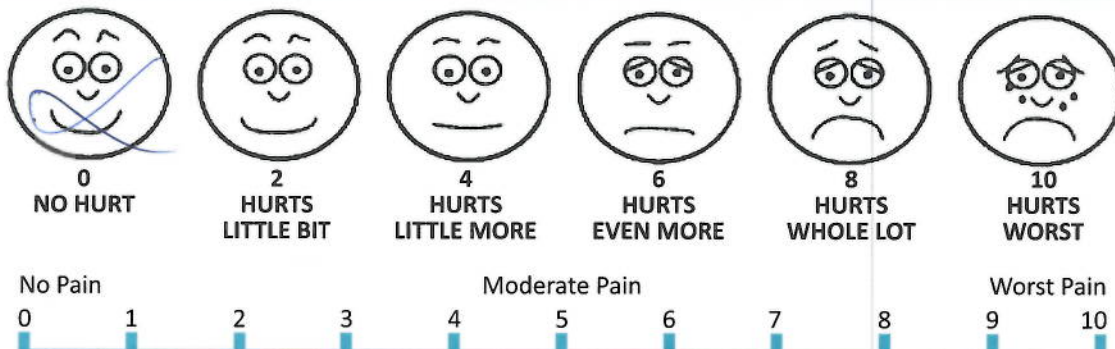
Are you allergic, or have you reacted adversely to any of the following:

	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)		X	
Penicillin or other antibiotics	X		
Asperin or Ibuprofen		X	
Reactions to metals	X		Nickel
Latex or rubber dam		X	
Foods		X	

Additional questions for women.

	Yes	No	Others, Please Specify
Are you pregnant or trying to get pregnant?		X	
if yes, expected delivery date: _____			
Are you taking oral contraceptives?		X	

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.