

File No: NORA 8200 GMA Email: LNDRA Mobile no .: OM. Nationality: OF Sex: Date of Birth: Others Family or Friends (9) Internet Newspapers How do you know about us? **MEDICAL HISTORY** Certain medical conditions can affect dental treatment and vice versa. Please complete this form by answering the questions. Chief Complaint: Yes No Others, Please Specify All details will be strictly confidential. 1 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? Have you ever had any complications following dental treatment? Are you a smoker? Do you have, or have you had any of the following Fainting / Seizures Low Blood Pressure Rheumatic Fever High Blood Pressure Leukemia **Epilepsy** Asthma Heart Attack Lung Disease Kidney Disease Liver Disease **Heart Disease** Hepatitis/Jaundice Thyroid Problem Diabetes **Tuberculosis** AIDS/HIV Infection Stroke Arthritis Cancer Creutzfeldt-Jakob disease (CJD) Others, Please Specify. Are you allergic, or have you reacted adversely to any of the following: Yes Others, Please Specify No Local anesthetics (Novocaine) Penicillin or other antibiotics Asperin or Ibuprofen Reactions to metals Latex or rubber dam V Foods Others, Please Specify Yes Additional questions for women. No 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 **HURTS HURTS HURTS** NO/HURT **HURTS HURTS**

WORST

Worst Pain

10

WHOLE LOT

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.

LITTLE MORE

Moderate Pain

EVEN MORE

LITTLE BIT

No Pain