

3400 File No:

Name: Saarang				
Mobile no.: 050 6916 184 Email: Sagrangi Ogmail	am			
Date of Birth: 29 06 2002 Sex: OM	Natio	onality:	Indian	
How do you know about us?	○ Ne	wspaper	o 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?		/		
Have you ever had any complications following dental treatment?		/		
Are you a smoker?				
Do you have, or have you had any of the following				
○ High Blood Pressure ○ Low Blood Pressure ○ Rheumatic Fev	er		Fainting / Seizures	
○ Asthma			Leukemia	
○ Heart Disease     ○ Kidney Disease     ○ Liver Disease			Lung Disease	
○ Thyroid Problem ○ Diabetes ○ Tuberculosis		C	Hepatitis/Jaundice	
○ Stroke ○ Arthritis ○ Cancer		AIDS/HIV Infection		
Creutzfeldt–Jakob disease (CJD)  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		V		
Reactions to metals				
Latex or rubber dam		-	e e e e e e e e e e e e e e e e e e e	
Foods				
Additional questions for women.	Yes	No	Others, Please Specify	
Are you pregnant or trying to get pregnant?				
if yes, expected delivery date:	T T			
Are you taking oral contraceptives?				
PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR	CURRENT	PAIN INT	TENSITY	
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MO HURT HURTS HURTS HURTS LITTLE BIT LITTLE MORE EVEN MORE	HL	JRTS DLE LOT	HURTS WORST	
No Pain Moderate Pain 0 1 2 3 4 5 6	7	8	Worst Pain 9 10	

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.