



File No:

3468

Name: <u>Darija mirkene</u>		
Mobile no.: <u>+447552856379</u>	Email: <u>Darjamirks@gmail.com</u>	
Date of Birth: <u>09-09-2004</u>	Sex: <input type="radio"/> M <input checked="" type="radio"/> F	Nationality: <u>Lithuania</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?		<input checked="" type="checkbox"/>	
Are you taking any medications, pills, or drugs?		<input checked="" type="checkbox"/>	
Have you ever been hospitalized or had a major operation?		<input checked="" type="checkbox"/>	
Have you ever had any complications following dental treatment?		<input checked="" type="checkbox"/>	
Are you a smoker?		<input checked="" type="checkbox"/>	

Do you have, or have you had any of the following	Yes	No	Others, Please Specify
<input type="radio"/> High Blood Pressure			<input type="radio"/> Fainting / Seizures
<input type="radio"/> Low Blood Pressure			<input type="radio"/> Leukemia
<input type="radio"/> Rheumatic Fever			<input type="radio"/> Lung Disease
<input type="radio"/> Asthma			<input type="radio"/> Hepatitis/Jaundice
<input type="radio"/> Heart Attack			<input type="radio"/> AIDS/HIV Infection
<input type="radio"/> Epilepsy			
<input type="radio"/> Heart Disease			
<input type="radio"/> Kidney Disease			
<input type="radio"/> Liver Disease			
<input type="radio"/> Thyroid Problem			
<input type="radio"/> Diabetes			
<input type="radio"/> Tuberculosis			
<input type="radio"/> Stroke			
<input type="radio"/> Arthritis			
<input type="radio"/> Cancer			
<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)		<input checked="" type="checkbox"/>	
Penicillin or other antibiotics		<input checked="" type="checkbox"/>	
Asperin or Ibuprofen		<input checked="" type="checkbox"/>	
Reactions to metals		<input checked="" type="checkbox"/>	
Latex or rubber dam		<input checked="" type="checkbox"/>	
Foods		<input checked="" type="checkbox"/>	

Additional questions for women.	Yes	No	Others, Please Specify
Are you pregnant or trying to get pregnant?		<input checked="" type="checkbox"/>	
if yes, expected delivery date: _____			
Are you taking oral contraceptives?		<input checked="" type="checkbox"/>	

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.