



File No: 3684

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 Date of Birth: July 9 '81 Sex:  M  F Nationality: Filipino  
 How do you know about us?  Family or Friends  Internet  Newspapers  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"/>	<input type="checkbox"/>	<u>↓ The ombosis</u>
Are you taking any medications, pills, or drugs?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>Apixiban, ke xian m,</u>
Have you ever been hospitalized or had a major operation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>CS</u>
Have you ever had any complications following dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you a smoker?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

**Do you have, or have you had any of the following**

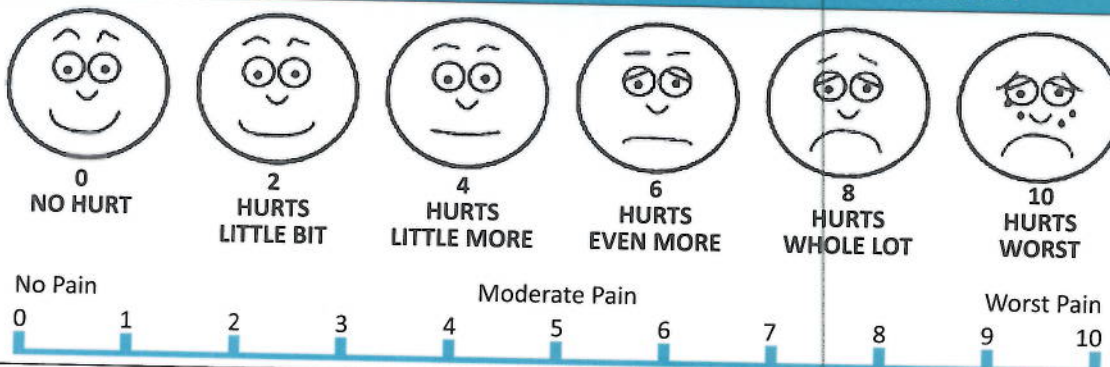
<input type="checkbox"/> High Blood Pressure	<input checked="" type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Rheumatic Fever	<input checked="" type="checkbox"/> Fainting / Seizures
<input checked="" type="checkbox"/> Asthma	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Thyroid Problem	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hepatitis/Jaundice
<input type="checkbox"/> Stroke	<input type="checkbox"/> Arthritis	<input checked="" type="checkbox"/> Cancer	<input type="checkbox"/> AIDS/HIV Infection
<input type="checkbox"/> Creutzfeldt-Jakob disease (CJD)	<input type="checkbox"/> Others, Please Specify	<u>N/A</u>	

Are you allergic, or have you reacted adversely to any of the following:	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Penicillin or other antibiotics	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Asperin or Ibuprofen	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Reactions to metals	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Latex or rubber dam	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Foods	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>seafood</u>

**Additional questions for women.**

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