DENTISTREE DENTAL CLINIC

File No: 4079

Name: DOLLY SAHLANI			
Mobile no.: 050-3453048	Email: —		
Date of Birth: 23-11-1983	Sex: ○ M ✓○ F	Nationality: INDIAN	
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: DENTAL ROUTINE CONSULTATION

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 NONE

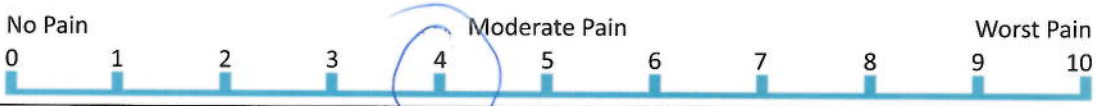
○ High Blood Pressure	○ Low Blood Pressure	○ Rheumatic Fever	○ Fainting / Seizures
○ Asthma	○ Heart Attack	○ Epilepsy	○ Leukemia
○ Heart Disease	○ Kidney Disease	○ Liver Disease	○ Lung Disease
○ Thyroid Problem	○ Diabetes	○ Tuberculosis	○ Hepatitis/Jaundice
○ Stroke	○ Arthritis	○ Cancer	○ AIDS/HIV Infection
○ 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		✓	
Reactions to metals		✓	
Latex or rubber dam		✓	
Foods		✓	

Additional questions for women.	Yes	No	Others, Please Specify
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

0	2	4	6	8	10
NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST



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.