



Name:	Blossom Ben Srid Amruth		
Mobile no.:	0168303702		
Date of Birth:	04/07/1997	Sex:	<input type="radio"/> M <input checked="" type="radio"/> F
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

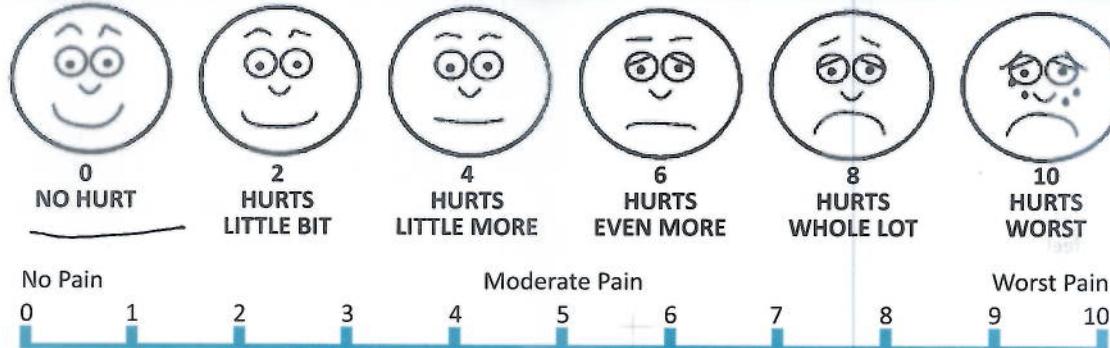
Certain medical conditions can affect dental treatment and vice versa.

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?			✓	
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				
<input type="radio"/> High Blood Pressure	<input type="radio"/> Low Blood Pressure	<input type="radio"/> Rheumatic Fever	<input type="radio"/> Fainting / Seizures	
<input type="radio"/> Asthma	<input type="radio"/> Heart Attack	<input type="radio"/> Epilepsy	<input type="radio"/> Leukemia	
<input type="radio"/> Heart Disease	<input type="radio"/> Kidney Disease	<input type="radio"/> Liver Disease	<input type="radio"/> Lung Disease	
<input type="radio"/> Thyroid Problem	<input type="radio"/> Diabetes	<input type="radio"/> Tuberculosis	<input type="radio"/> Hepatitis/Jaundice	
<input type="radio"/> Stroke	<input type="radio"/> Arthritis	<input type="radio"/> Cancer	<input type="radio"/> AIDS/HIV Infection	
<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)			✓	
Penicillin or other antibiotics			✓	
Aspirin 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



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.