DENTISTREE DENTAL CLINIC

File No: 4534

Name: Rima			
Mobile no.: +971 52 300 3691	Email: Rimaa.Eid@icloud.com		
Date of Birth: 4/8/2003	Sex: ○ M ◉ F	Nationality:	
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?		/	
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?		/	

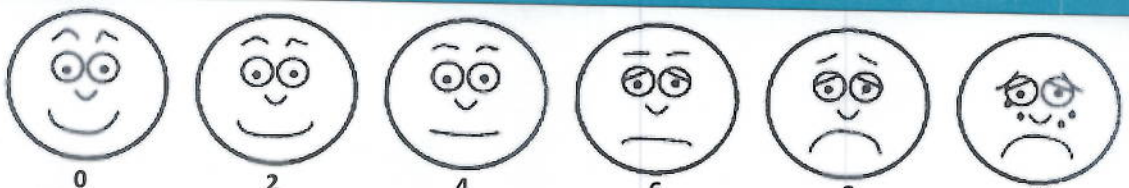
Do you have, or have you had any of the following

○ High Blood Pressure	○ Low Blood Pressure	○ Rheumatic 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 _____	

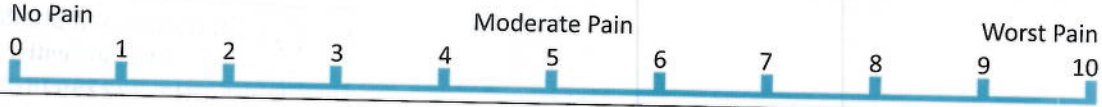
Are you allergic, or have you reacted adversely to any of the following:	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)		/	
Penicillin or other antibiotics		/	
Asperin or Ibuprofen		/	
Reactions to metals		/	
Latex or rubber dam		/	
Foods		/	

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 NO HURT | 2 HURTS LITTLE BIT | 4 HURTS LITTLE MORE | 6 HURTS EVEN MORE | 8 HURTS WHOLE LOT | 10 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.