Health History and Dental Treatment Record

No.________

Name :____ Age: ______

Male_____ Female _____ are you pregnant? Yes _____ No _____

What district are you from?____________________________________

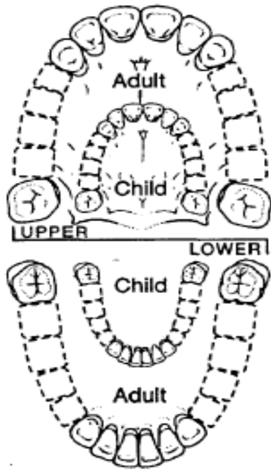
Are you currently taking any medication Yes_____ No _____

Are you allergic to any medications? Yes _____ No ______

Do you have High blood pressure? Yes_____ No ______

Blood pressure______________________

Existing Conditions:



Treatment Needed:

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Treatment Rendered:

Date	Tooth #	Procedure	Comments	Dent init

Treatment Provided By: __________________________________ Date:_____________