



Name: SAIFUDDIN BARBHAIWALA
 Mobile no.: 0555090952 Email: saifarif@gmail.com
 Date of Birth: 05/10/86 Sex: M F Nationality: INDIA
 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"/>	
Are you taking any medications, pills, or drugs?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>Euthyrox, Glucophage</u>
Have you ever been hospitalized or had a major operation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>Tongueidectomy</u>
Have you ever had any complications following dental treatment?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Are you a smoker?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

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

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Fainting / Seizures
<input 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 checked="" 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 type="checkbox"/> Cancer	<input type="checkbox"/> AIDS/HIV Infection
<input type="checkbox"/> Creutzfeldt-Jakob disease (CJD)	<input type="checkbox"/> Others, Please Specify _____		

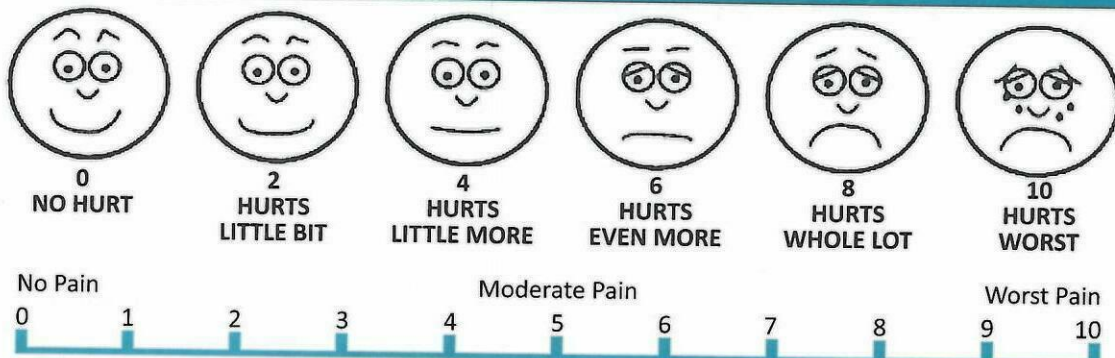
Are you allergic, or have you reacted adversely to any of the following:

	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 type="checkbox"/>	<input checked="" type="checkbox"/>	

Additional questions for women.

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

Signature of Patient, Parent or Guardian

Date

15/09/2023

PATIENT ASSESSMENT FORM

Oral Health Information Adult

Do you gag easily?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you wear dentures?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
Does food catch between your teeth?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have difficulty in chewing your food?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you chew on only one side of your mouth?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do your gums bleed easily?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do your gums bleed when you floss?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do your gums feel swollen or tender?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are your teeth sensitive?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you take fluoride supplements?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you prefer to save your teeth?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you want complete dental care?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No

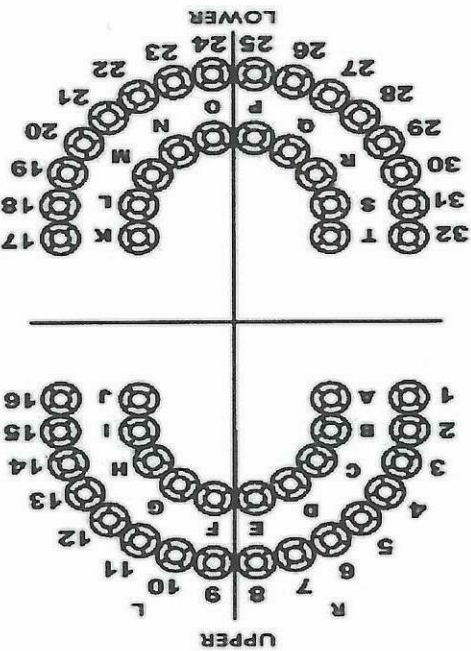
Oral Health Information Pediatric/Child

Does your child use a toothpaste with fluoride in it?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you help your child with toothbrushing?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have your child experience in a dental treatment?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have your child ever had cavities?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Does your child complain of mouth pain?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Does your child take a bottle to bed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Does your child loves to eat foods like Chocolates, candy, snacks a lot?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Does your child gums bleed easily?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Health Information for TMJ

Do you clench or grind your jaws frequently?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Does your jaw get stuck so that you can't open freely?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Does it hurt when you chew or open wide to take a bite?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have earaches or pain in front of the ears?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have any jaw headaches upon awaking in the morning?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you find jaw pain or discomfort extremely frustrating /depressing?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have a temporomandibular (jaw) disorder (TMD)?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you unable to open your mouth as far as you want?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you aware of an uncomfortable bite?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you had a blow to the jaw (trauma)?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you a habitual gum chewer or pipe smoker?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

DENTAL CHARTING



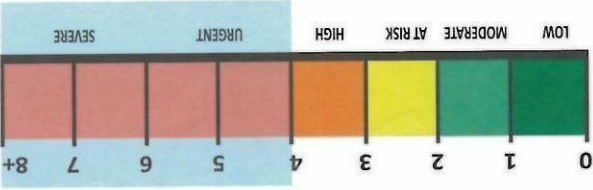
Category	0 = healthy	1 = changes	2 = unhealthy	Score
Lips	Smooth, Pink, Moist	Dry, chapped, red at corners	Swelling or lump ulcerated at corners	
Tongue	Normal, Moist, Pink	Patchy, fissured, red, coated	Patch that is red & ulcerated, swollen	
Gums & Tissues	Pink, Moist, Smooth	Dry, shiny, rough, swollen 1 to 6 teeth	Swollen, bleeding, generalized redness	
Saliva	Moist Tissues, Watery	Dry, sticky tissues, Little saliva present	No saliva present	
Natural Teeth	No Decayed/ Broken Teeth	1 to 3 decayed/ 1 broken teeth	4 or more decayed & broken teeth	
Denture(s)	No Broken Areas	1 Broken Area	More than 1 broken	

FALL RISK ASSESSMENT

Falls are common for 65yrs of age and older.

Points	Yes	No
Do you fallen in the pass years?	<input type="checkbox"/>	<input type="checkbox"/>
Are you using or advice to use cane or walker?	<input type="checkbox"/>	<input type="checkbox"/>
Are you lose a balance while walking?	<input type="checkbox"/>	<input type="checkbox"/>
You Worry about falling?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use your arm/s to push your self from a chair?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble stepping up onto a curb/steps?	<input type="checkbox"/>	<input type="checkbox"/>
Are you sways when standing stationary?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take short narrow step?	<input type="checkbox"/>	<input type="checkbox"/>
Are you stumble often or look at the ground when you walk?	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently have to rush to the toilet?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have lost some feeling in one or both of your feet?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take any medication to feel light headed or sleepy?	<input type="checkbox"/>	<input type="checkbox"/>
Total Points	14	

YOUR FALL RISK



Dr. Priyanka Kiran
General Dentist
DENTISTREE DENTAL CLINIC
DHA-00148697-002

Dentist Stamp :

Date :

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