# DENTISTREE DENTAL CLINIC

File No: 3298

| | | | |
|---|---|---|---|
| Name: Ghenwa Naser | | | |
| Mobile no.: 050 2267681 | Email: ghenwa.nasser@yahoo.com | | |
| Date of Birth: 01 Jul 1987 | Sex: ○ M ● F | Nationality: Syrian | |
| 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? | ✓ | | |

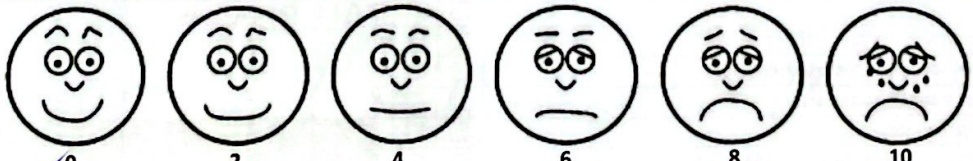
**Do you have, or have you had any of the following** N/A

| | | | |
|---|---|---|---|
| ○ 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 _____ | |

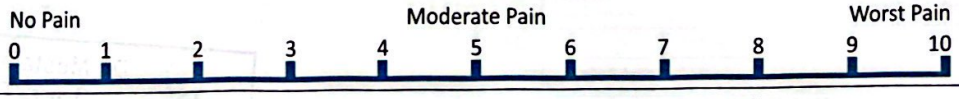
| Are you allergic, or have you reacted adversely to any of the following: | Yes | No | Others, Please Specify |
|---|---|---|---|
| Local anesthetics (Novocaine) | | ✓ | |
| Penicillin or other antibiotics | | ✓ | |
| Asperin or Ibuprofen | | ✓ | |
| Reactions to metals | | ✓ | |
| Latex or rubber dam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

Signature of Patient, Parent or Guardian

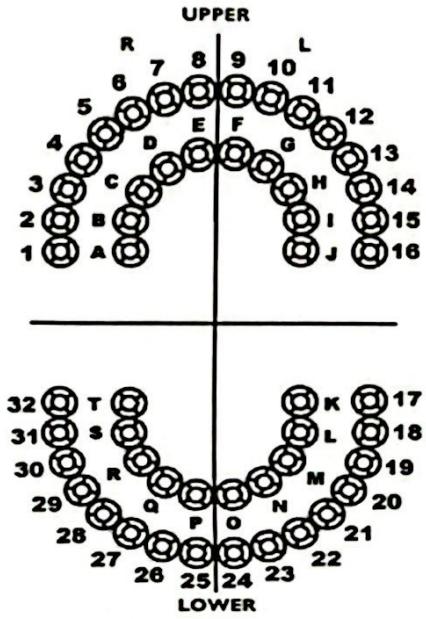
24.02.2024
Date

# PATIENT ASSESSMENT FORM

| Oral Health Information Adult | Yes | No |
|---|---|---|
| Do you gag easily? | ☐ | ☑ |
| Do you wear dentures? | ☐ | ☑ |
| Does food catch between your teeth? | ☐ | ☑ |
| Do you have difficulty in chewing your food? | ☐ | ☑ |
| Do you chew on only one side of your mouth? | ☐ | ☑ |
| Do your gums bleed easily? | ☐ | ☑ |
| Do your gums bleed when you floss? | ☐ | ☑ |
| Do your gums feel swollen or tender? | ☐ | ☑ |
| Are your teeth sensitive? | ☐ | ☑ |
| Do you take fluoride supplements? | ☐ | ☑ |
| Do you prefer to save your teeth? | ☐ | ☑ |
| Do you want complete dental care? | ☑ | ☐ |

| Oral Health Information Pediatric/Child | Yes | No |
|---|---|---|
| Does your child use a thoothpase with flouride in it? | ☐ | ☐ |
| Do you help your child with toothbrushing? | ☐ | ☐ |
| Have your child experince in a dental treatment? | ☐ | ☐ |
| Have your child ever had cavities? | ☐ | ☐ |
| Does your child complain of mouth pain? | ☐ | ☐ |
| Does your child take a bottle to bed? | ☐ | ☐ |
| Does your Child loves to eat foods like Chocolates, candy, snacks a lot? | ☐ | ☐ |
| Does your child gums bleed easily? | ☐ | ☐ |

## DENTAL CHARTING



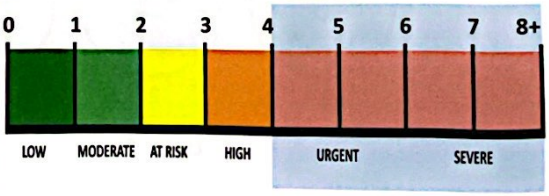

| Health Information for TMJ | Yes | No |
|---|---|---|
| Do you clench or grind your jaws frequently? | ☐ | ☐ |
| Do your jaws ever feel tired? | ☐ | ☐ |
| Does your jaw get stuck so that you can't open freely? | ☐ | ☐ |
| Does it hurt when you chew or open wide to take a bite? | ☐ | ☐ |
| Do you have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

| 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 Tissues parched | |
| 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? | 2 | ☐ | ☐ |
| Are you using or advice to use cane or walker? | 2 | ☐ | ☐ |
| Are you lose a balance while walking? | 1 | ☐ | ☐ |
| You Worry about falling? | 1 | ☐ | ☐ |
| Do you use your arm/s to push your self from a chair? | 1 | ☐ | ☐ |
| Do you have trouble stepping up onto a crub/steps? | 1 | ☐ | ☐ |
| Are you sways when standing stationary? | 1 | ☐ | ☐ |
| Do you take short narrow step? | 1 | ☐ | ☐ |
| Are you stamble often or look at the ground when you walk? | 1 | ☐ | ☐ |
| Do you frequently have to rush to the toilet? | 1 | ☐ | ☐ |
| Do you have lost some feeling in one or both of your feet? | 1 | ☐ | ☐ |
| Do you take any medication to feel light headed or sleepy? | 1 | ☐ | ☐ |
| | 14 | ☐ | ☐ |
| **Total Points** | | | |

**YOUR FALL RISK →**




Dr. Mostafa Abdalla
General Dentist
DENTISTREE DHA-00222048-001
DENTISTREE DENTAL CLINIC

Dentist Stamp :

Date : _____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