

469 File No:

Mobile no.: (507457317 Email:				
Date of Birth: 23°03° 2005 Sex: OM OF	Nati	onality:	Indian	
How do you know about us?	ON	○ Newspapers ○ Others		
MEDICAL HISTORY				
Certain medical conditions can affect dental treatment and vic	e 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?		1		
Have you ever been hospitalized or had a major operation?		1		
Have you ever had any complications following dental treatment?		-		
Are you a smoker?		V		
Do you have, or have you had any of the following				
○ High Blood Pressure ○ Low Blood Pressure ○ Rheumatic F	Fever		Fainting / Seizures	
Asthma Heart Attack Epilepsy		Leukemia		
○ Heart Disease ○ Kidney Disease ○ Liver Diseas	e		Lung Disease	
○ Thyroid Problem ○ Diabetes ○ Tuberculosis	S	19	O Hepatitis/Jaundice	
○ Stroke ○ Arthritis ○ Cancer		N.	AIDS/HIV Infection	
Creutzfeldt–Jakob disease (CJD) Others, Plea	se 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		V		
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 YOU	R CURREN	PAIN I	NTENSITY	
	) (É	òò	100	

10 NO HURT **HURTS HURTS** HURTS EVEN MORE **HURTS HURTS** LITTLE BIT LITTLE MORE WHOLE LOT WORST No Pain Moderate Pain Worst Pain 3 10

Oral Health Information Adult	Yes	No
Do you gag easily?		6
Do you wear dentures?		0
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?		Z
Do your gums feel swollen or tender?		Z
Are your teeth sensitive?		Z
Do you take fluoride supplements?		
Do you prefer to save your teeth?	Z	
Do you want complete dental care?	Z	

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?		

8 7 8 5 6 0 0	9 10 11 (D) 12
4 例 8 E 3 例 6 例 2 例 8 例 1 例 4 例	© 6 013 © 6 013 © 1 014 © 1 015 © 1 016
32 © T © 31 © 5 © 5 © 6 © 6 © 6 © 6 © 6 © 6 © 6 © 6	©к © 17 © L © 18 © M © 19 © N © 20 ° N © 21 © 00 21 24 23

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	

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			Control Section Control	
Are you lose a balance while walking?	1			☐ YOUR ☐ FALL RISK →	
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			0 1 2 3 4 5 6 7 8	
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		LOW MODERATE AT RISK HIGH URGENT	LOW MODERATE AT RISK HIGH URGENT SEVERE	
Do you have lost some feeling in one or both of your feet?	1			LOW MODERATE AI KISK HIGH UNGERT SEVERE	
Do you take any medication to feel light headed or sleepy?	1				
	14			- I Divisa	
Total Poin	ts(	Dr.	Pe	arl Pinto Dr. Pe	

DENTISTREE DENTAL CLINIC

Shop 3, Wasl Port Views 8, Next to Hyatt Place, Al Mina Road, Jumeirah 1, Dubai United Arab Emirates DHA-0/422 Dentist Stamp :

Date : \_\_\_\_\_