

4610 File No: Name: Mobile no.: Email: walen Date of Birth: Sex: M OF Nationality: How do you know about us? Family or Friends ○ Internet O Others Newspapers **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 Others, Please Specify No 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: 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 Others, Please Specify No 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 10 NO HURT **HURTS HURTS HURTS** HURTS **HURTS** LITTLE BIT LITTLE MORE **EVEN MORE** WHOLE LOT WORST No Pain Moderate Pain Worst Pair 8

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.

Oral Health Information Adult			Yes	No		DENTAL CHARTING					
Do you gag easily?											
Do you wear dentures?						UPPER					
Does food catch bet ween your teeth?	food catch bet ween your teeth?					R 7 8 9 10 1					
Do you have difficul y in chewing your food?											
Do you chew on only one side of your mouth?							5_600	2000	10 12		
Do your gums bleed easily?						4	D D	E F	(O)		
Do your gums bleec when you floss?						9.	(S)	2)8 86	2 013		
Do your gums feels vollen or tender?						2 6 8 6 1 0 15					
Are your teeth sens tive?	Control (1) The Control (1) Th										
Do you take fluoride supplements?						100 400			@1@1	16	
Do you prefer to save your teeth?											
Do you want complete dental care?											
Oral Health Information Pediatric/Child			Yes	No	32 (D) T (D) (O) K (O) 17					17	
Does your child use a thoothpase with flo						316 86 8 8 8 8				18	
Do you help your child with toothbrushing?			H			300 0 0 0 19					
Have your child experince in a dental treatment?					OR ORION OF						
Have your child ever had cavities?			H			25	, _@~ <sub>0</sub>	PO	N @ 20	6	
Does your child complain of mouth pain?							28 27	2000	221		
Does your child take a bottle to bed?				H			26	25 24	23		
Does your Child love to eat foods like Chocolates, candy, snacks a lot?				=		LOWER					
Does your child gum bleed easily?											
good your orma game area cashy.					L						
				0.000 -						1920 1000 1000	
Health Information for TMJ			Yes	No		Category	0 = healthy	1 = changes	2 = unhealthy	Score	
Do you clench or grir d your jaws frequently?						Lips	Smooth, Pink, Moist	Dry, chapped, red at corners	Swelling or lump ulcerated at corners		
Do your jaws ever feel tired?							MINIST	red at corners	ulcerated at corners		
	aw get stick so that you can't open freely?					Tongue	Normal,	Patchy, fissured,			
	you chew or open wide to take a bite?						Moist, Pink r	red, coated	, coated ulcerated, swollen		
	have earaches or pain in front of the ears?					Gums &	Pink, Moist,	Dry, shiny, rough,	Swollen, bleeding		
Do you have any jaw headaches upon awaking in the morning?  Do you find jaw pain or discomfort extremely frustrating /depressing?						Tissues	Smooth	swollen 1 to 6 teeth	Generalized redness		
Do you have a temporomandibular (jaw) disorder (TMD)?						Saliva	Moist Tissues,	Dry, sticky tissues,	No saliva present		
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?					Janva		Watery	Little saliva present			
Are you unable to open your mouth as far as you want?			H	Н	Natural Teeth	Natural	No Decayed/	1 to 3 decayed /	4 or more decayed		
Are you aware of an uncomfortable bite?			-	-			Broken Teeth	1 broken teeth	& broken teeth		
lave you had a blow to the jaw (trauma)?			H				No Dealess				
Are you a habitual gum chewer or pipe sm			H			Denture(s)	No Broken Areas	1 Broken Area	Broken Area   More than 1 broken		
Are you a manitual germenewer or pipe sin	ioner			ш	L						
The second secon			-				Service Services		Shell of As	TO THE PARTY	
the same of the same of	FALL RI	SK AS	SSE	55N	<b>MEN</b>			A SUR LINE			
Falls are common for 65yrs of age and	older	Points	Yes	No							
Do you fallen in the pass years?		2									
Are you using or adv ce to use cane or wa	ker?	2			116						
Are you lose a balance while walking?		1				DUR					
You Worry about fall ng?		1			FA	LL RI	SK ⇒				
Do you use your arm sto push your self for		1									
Do you have trouble stepping up onto a co	ub/steps?	1			0	1	2 3	4 5	6 7	8+	
Are you sways when standing stationary?		1			<u> </u>	-	i	1			
Do you take short na row step?		1									
Are you stamble often or look at the grou		1				<b>1998</b>					
Do you frequently have to rush to the toil		1			LOV	W MODERA	TE AT RISK I	HIGH URGE	NT SEVE	RE	
Do you have lost son e feeling in one or b	Control of the Contro	1			-3.						
Do you take any medication to feel light h	eaded or sleepy?	1									
	Total Points	14									
	lotal Points						III Security		0.0		
Shop 3, Wasl Port Views 8,		Dentist Stamp :									

Shop 3, Wasl Port Vievs 8, Next to Hyatt Place, Al Mina Road, Jumeirah 1, Dubai United Arab Emirates

Dentist Stamp .

Date