

File No: 4704 NANDWANI Name: VARKHA Mobile no.: 865-604-3717 Email: nandwanivarkha@yahoo.com Date of Birth: 08-26-64 O.F Sex: OMNationality: U.S How do you know about us? **Pamily** or Friends ○ Internet Newspapers O 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 Nb Others, Please Specify Are you under a physician's care now? LEVO THYROXIN, ATOROVASTATO 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 AIDS/HIV Infection Cancer NA Creutzfeldt-Jakob disease (CJD) Others, Please Specify. Are you allergic, or have you reacted adversely to any of the following: Nd 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 Nd 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 10 NO HURT **HURTS HURTS HURTS** HURT: **HURTS** LITTLE BIT LITTLE MORE **EVEN MORE** WHOLE LOT WORST No Pain Moderate Pain Worst Pain 10

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		DE	NTAL CHAR	TING
Do you gag easily?		2				
Do you wear dentures?		0			UPPER	
Does food catch between your teeth?		8		R	-1-	L
Do you have difficulty in chewing your food?				6 7	331	10
Do you chew on only one side of your mouth?		8		5 60	300	D)
Do your gums bleed easily?					E	a
Do your gums bleed when you floss?				Ø .	966	1
Do your gums feel swollen or tender?		Ø	3	<b>D</b> , <b>(6)</b>		6
Are your teeth sensitive?			20	9 = 9		9
Do you take fluorice supplements?		0	10	g) A (Q)	1	(3)
Do you prefer to sa ve your teeth?						
Do you want complete dental care?			_		_	
				~ ~		_
Oral Health Information Pediatric/Child	Yes	No	32 9	979		8
Does your child use a thoothpase with flouride in it?			310	3 ° C		S
			30		8-1-6	SO,
Do you help your child with toothbrushing?				720 "" [4		
Have your child experince in a dental treatment?			29	, Q	A COLON	N C
			29	28		6
Have your child experince in a dental treatment?			29	28 27	3 <u>@</u> @	
Have your child experince in a dental treatment? Have your child ever had cavities?			29	28 0	25 24	N 13
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?			29	28 0	25 24 LOWER	N 13
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?			25	28 0 27 26	25 24 LOWER	33
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 guns bleed easily?			25	28 07 26	P 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23
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?			Category	28 27 26 0 = healthy	25 24 Lower	2 = u
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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 gun is bleed easily?  Health Information for TMJ  Do you clench or grind your jaws frequently?	Yes	No No	Lips	Smooth, Pink, Moist	Dry, chapped, red at corners	Swell ulcerat
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FALL RISK ASSESSMENT									
Falls are common for 65yrs of age and older.	Points	Yes	No						
Do you fallen in the pass years?	2		V						
Are you using or advice to use cane or walker?	2		V						
Are you lose a balance while walking?	1		0	YOUR					
You Worry about falling?	1		V	FALL RISK ->					
Do you use your arm/s to push your self from a chair?	1		Ø,						
Do you have trouble stepping up onto a crub/steps?	1		VZ,						
Are you sways when standing stationary?	1		Ø,	0 1 2 3 4 5 6 7 8					
Do you take short narrow step?	1		V						
Are you stamble often or look at the ground when you walk?	1		V/						
Do you frequently have to rush to the toilet?	1								
Do you have lost some feeling in one or both of your feet?	1		1	Dr. Dipti Sanghavi					
Do you take any me lication to feel light headed or sleepy?	1	П	1	Specialist Periodontics					

**Total Points** 

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

Dentist Stamp:

DENTISTREE DHA-00128316-003

DENTISTREE DENTAL CLINIC

Date

2 = unhealthy

Swelling or lump ulcerated at corners

Patch that is red &

ulcerated, swollen

Swollen, bleeding

Generalized redness

No saliva present Tissues parched

4 or more decayed

& broken teeth

More than 1 broken

Score