



DENTISTREE DENTAL CLINIC

File No:

4953

Name: Sahil Chandwani

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Date of Birth: 07/Jan/99

Sex: ☒ M ☐ F

Nationality: Indian

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

☐ 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

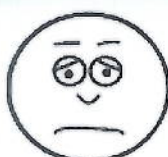
Others, Please Specify

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 HURT2
HURTS
LITTLE BIT4
HURTS
LITTLE MORE6
HURTS
EVEN MORE8
HURTS
WHOLE LOT10
HURTS
WORST

No Pain

Moderate Pain

Worst Pain

0 1 2 3 4 5 6 7 8 9 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.

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 curb/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				

FALL RISK ASSESSMENT

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?	☐	☐	☐

Oral Health Information Pediatric/Child		Yes	No
Does your child use a toothpaste with fluoride in it?		☐	☐
Do you help your child with toothbrushing?		☐	☐
Have your child experience 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?		☐	☐

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?	☒	☐

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	

SEVERE URGENT HIGH AT RISK MODERATE LOW

8+ 7 6 5 4 3 2 1 0

YOUR FALL RISK

Dr. Pearl Pinto
General Dentist
DENTISTREE DHA-04205785-003
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