



DENTISTREE DENTAL CLINIC

File No:

4955

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Date of Birth: <u>07/SEP/1962</u>		Sex: ☐ M ☒ F	Nationality: <u>INDIAN</u>
How do you know about us? ☐ Family or Friends ☐ Internet ☐ Newspapers ☐ Others			

MEDICAL HISTORY

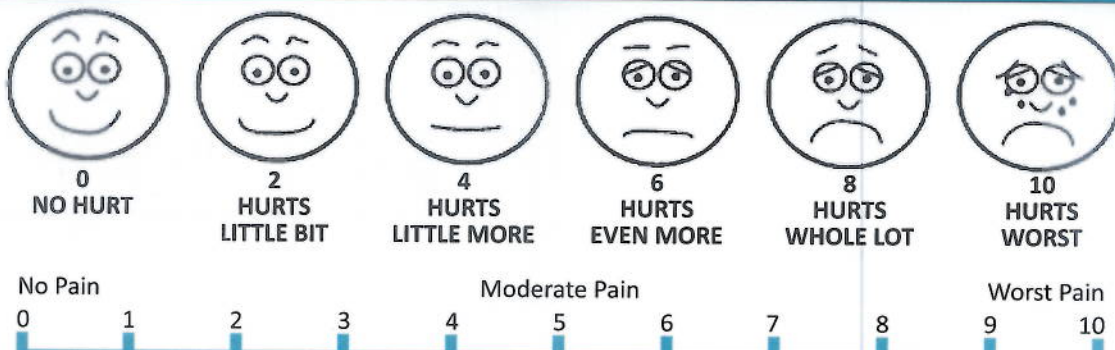
Certain medical conditions can affect dental treatment and vice versa.

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



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.

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	Lips	Tongue	Gums & Tissues	Saliva	Natural Teeth	No Broken Areas	Denture(s)
0 = healthy	Smooth, Pink, Moist	Normal, Moist, Pink	Pink, Moist, Smooth	Moist Tissues, Watery	No Decayed/ Broken Teeth	No Broken Areas	
1 = changes	Dry, chapped, red at corners	Patchy, fissured, red, coated	Dry, shiny, rough, swollen 1 to 6 teeth	Dry, sticky tissues, little saliva present	1 to 3 decayed/ 1 broken teeth	1 Broken Area	
2 = unhealthy	Swelling or lump ulcerated at corners	Patch that is red & ulcerated, swollen	Swollen, bleeding Generalized redness	No saliva present	4 or more decayed & broken teeth	More than 1 broken	
Score							

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 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?	☐	☐

UPPER

LOWER

DENTAL CHARTING