



DENTISTREE DENTAL CLINIC

File No:

5001

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Date of Birth: 05.01.1981		Sex: ☐ M ☐ F	Nationality: Iran
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:			
Local anesthetics (Novocaine)	Yes	No	Others, Please Specify
Penicillin or other antibiotics		☒	
Asperin or Ibuprofen		☒	
Reactions to metals		☒	
Latex or rubber dam		☒	
Foods		☒	
Additional questions for women.			
Are you pregnant or trying to get pregnant?	Yes	No	Others, Please Specify
if yes, expected delivery date: _____		☒	
Are you taking oral contraceptives?		☒	

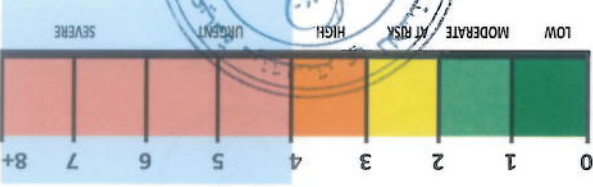
PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY

0 NO HURT	2 HURTS LITTLE BIT	4 HURTS LITTLE MORE	6 HURTS EVEN MORE	8 HURTS WHOLE LOT	10 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.

Date: 18/04/2025

Dentist Stamp:



YOUR FALL RISK

FALL RISK ASSESSMENT

Falls are common for 65yrs of age and older.	Points	Yes	No	Total Points
Do you fall in the past years?	2	☐	☐	14
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 stumble 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	☐	☐	
		☐	☐	
		☐	☐	

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?	☒	☐
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, ulcerated at corners		
Tongue	Normal, Moist, Pink	Patchy, fissured, red, coated, ulcerated, swollen		
Gums & Tissues	Pink, Moist, Smooth	Dry, shiny, rough, swollen 1 to 6 teeth, generalized redness		
Saliva	Moist Tissues, Watery	No saliva present, Dry, sticky tissues, Little saliva present		
Natural Teeth	No Decayed/ Broken Teeth	1 to 3 decayed/ 1 broken teeth & 4 or more decayed		
Denture(s)	No Broken Areas	1 Broken Area	More than 1 broken	

DENTAL CHARTING