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Date of Birth: 05/12/1997

Sex: ☒ M ☐ F

Nationality: Lebanon

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



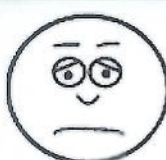
0
NO HURT



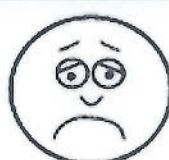
2
HURTS
LITTLE BIT



4
HURTS
LITTLE MORE



6
HURTS
EVEN MORE



8
HURTS
WHOLE LOT



10
HURTS
WORST

No Pain

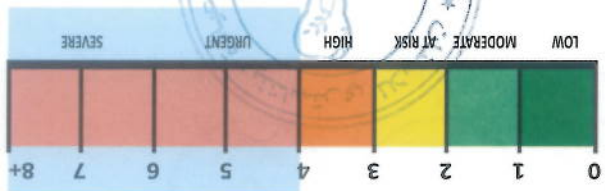
Moderate Pain

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 : 01/05/25
Dentist Stamp :



YOUR FALL RISK →

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 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	☐	☐
Total Points		14	☐	☐

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, 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	Dry, sticky tissues, No saliva present		
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	

