



DENTISTREE DENTAL CLINIC

File No:

5093

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Date of Birth: 01/01/1964	Sex: ☐ M ☒ F	Nationality: British	
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 0 1 2 3 4 5 6 7 8 9 10 Worst Pain					

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 : 16/05/25
Dentist Stamp :



YOUR FALL RISK →

Points		Total Points	
Falls are common for 65yrs of age and older.	No	1	1
Do you fall in the past years?	No	1	1
Are you using or advice to use cane or walker?	No	1	1
Are you lose a balance while walking?	No	1	1
You Worry about falling?	No	1	1
Do you use your arm/s to push your self from a chair?	No	1	1
Do you have trouble stepping up onto a curb/steps?	No	1	1
Are you sways when standing stationary?	No	1	1
Do you take short narrow step?	No	1	1
Are you stumble often or look at the ground when you walk?	No	1	1
Do you frequently have to rush to the toilet?	No	1	1
Do you have lost some feeling in one or both of your feet?	No	1	1
Do you take any medication to feel light headed or sleepy?	No	1	1
14		14	

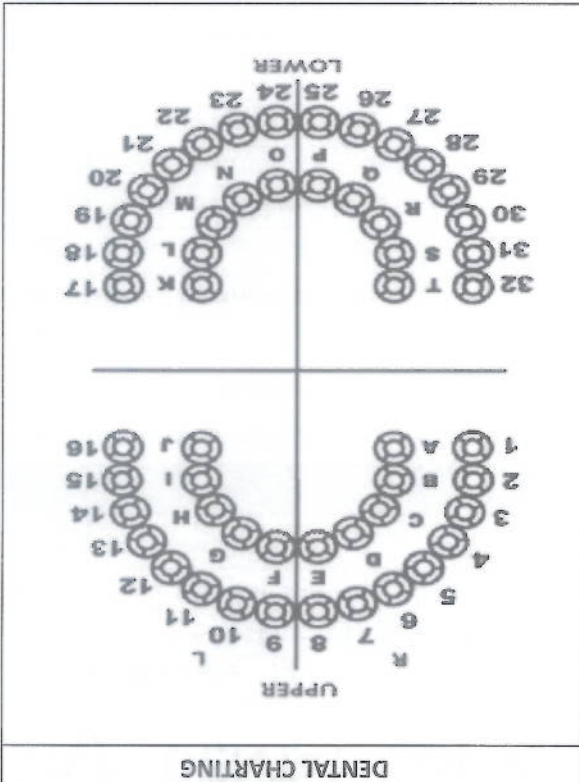
FALL RISK ASSESSMENT

Health Information for TMJ	
Do you clench or grind your jaws frequently?	No
Do your jaws ever feel tired?	No
Does your jaw get stuck so that you can't open freely?	No
Does it hurt when you chew or open wide to take a bite?	No
Do you have earaches or pain in front of the ears?	No
Do you have any jaw headaches upon awaking in the morning?	No
Do you find jaw pain or discomfort extremely frustrating /depressing?	No
Do you have a temporomandibular (jaw) disorder (TMD)?	No
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	No
Are you unable to open your mouth as far as you want?	No
Are you aware of an uncomfortable bite?	No
Have you had a blow to the jaw (trauma)?	No
Are you a habitual gum chewer or pipe smoker?	No

Oral Health Information Pediatric/Child	
Does your child use a toothpaste with fluoride in it?	No
Do you help your child with toothbrushing?	No
Have your child experience in a dental treatment?	No
Have your child ever had cavities?	No
Does your child complain of mouth pain?	No
Does your child take a bottle to bed?	No
Does your child loves to eat foods like Chocolates, candy, snacks a lot?	No
Does your child gums bleed easily?	No

Oral Health Information Adult	
Do you gag easily?	No
Do you wear dentures?	No
Does food catch between your teeth?	No
Do you have difficulty in chewing your food?	No
Do you chew on only one side of your mouth?	No
Do your gums bleed easily?	No
Do your gums bleed when you floss?	No
Do your gums feel swollen or tender?	No
Are your teeth sensitive?	No
Do you take fluoride supplements?	No
Do you prefer to save your teeth?	No
Do you want complete dental care?	No

Category	Lips	Tongue	Gums & Tissues	Saliva	Natural Teeth	Denture(s)
0 = healthy	Smooth, Pink, Moist	Normal, Pink, Moist	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						



DENTAL CHARTING