



DENTISTREE DENTAL CLINIC

File No:

5127.

Name: <u>AIBA AMANULLAH</u>			
Mobile no.: <u>0555420360</u>	Email: <u>hiba.amanullah@gmail.com</u>		
Date of Birth: <u>14/06/25</u>	Sex: ☐ M ☒ F	Nationality: <u>Pakistan</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: Bleeding gums

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 | | |

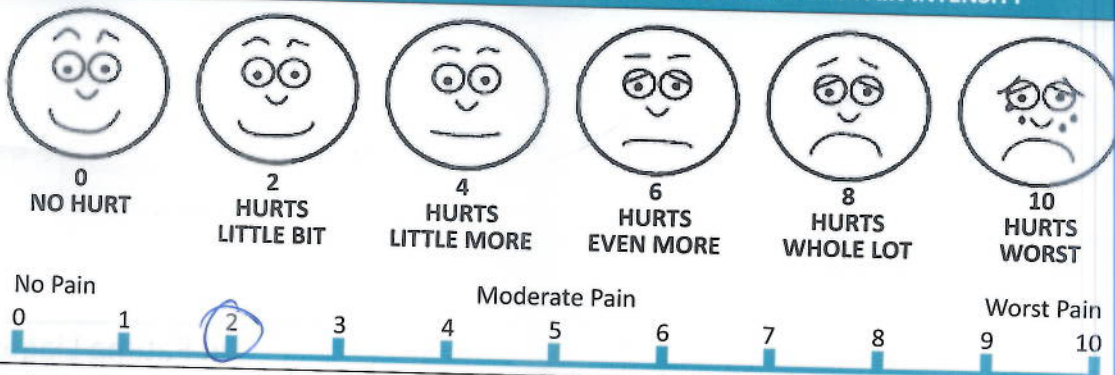
Are you allergic, or have you reacted adversely to any of the following:

	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)		☒	
Penicillin or other antibiotics		☒	
Asperin or Ibuprofen		☒	
Reactions to metals		☒	
Latex or rubber dam		☒	
Foods		☒	<u>sole fish</u>

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.

Dr. Fatima Liyagat
General Dentist
DHA-57761808-001
DENTISTREE DENTAL CLINIC



FALL RISK ASSESSMENT

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 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 crub/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	☐	☐	☐
Total Points		14	☐	☐

Category	Lips	Tongue	Gums & Tissues	Saliva	Natural Teeth	No Broken Areas	1 Broken Area	More than 1 broken	Score
0 = healthy	Smooth, Pink, Moist	Normal, Moist, Pink	Pink, Moist, Smooth	Moist Tissues, Watery	No Decayed/ Broken Teeth	No Broken Areas	1 Broken Area	More than 1 broken	0 = healthy
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	1 Broken Area	More than 1 broken	1 = changes
2 = unhealthy	Swelling or lump ulcerated at corners	Patch that is red & ulcerated, swollen	Swollen, bleeding Generalized redness	No saliva present Tissues parched	4 or more decayed & broken teeth	1 Broken Area	1 Broken Area	More than 1 broken	2 = unhealthy

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?	☒	☐

