



File No:

\$133

## MEDICAL HISTORY

Please complete this form by answering the questions.

**Chief Complaint:**

Do you have, or have you had any of the following

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

**Additional questions for women.**

if yes, expected delivery date:

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY

No Pain

### Moderate Pain

Worst Pain

| Digit | Frequency |
|-------|-----------|
| 0     | 1         |
| 1     | 1         |
| 2     | 1         |
| 3     | 1         |
| 4     | 1         |
| 5     | 1         |
| 6     | 1         |
| 7     | 1         |
| 8     | 1         |
| 9     | 1         |

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: 04/05/25  
Dentist Stamp:

**Dr. Negin Shahabzadeh**  
General Dentist  
DENTISTREE DHA-56247950-005  
DENTISTREE DENTAL CLINIC



**YOUR FALL RISK** →

### FALL RISK ASSESSMENT

| Falls are common for 65yrs of age and older.               | Points | Yes                      | No                       |
|------------------------------------------------------------|--------|--------------------------|--------------------------|
| Do you fallen in the pass years?                           | 2      | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you using or advice to use cane or walker?             | 2      | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you lose a balance while walking?                      | 1      | <input type="checkbox"/> | <input type="checkbox"/> |
| You Worry about falling?                                   | 1      | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use your arm/s to push your self from a chair?      | 1      | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have trouble stepping up onto a curb/steps?         | 1      | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you sways when standing stationary?                    | 1      | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you take short narrow step?                             | 1      | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you stumble often or look at the ground when you walk? | 1      | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you frequently have to rush to the toilet?              | 1      | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have lost some feeling in one or both of your feet? | 1      | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you take any medication to feel light headed or sleepy? | 1      | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Total Points</b>                                        | 14     | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

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

| Category       | 0 = healthy              | 1 = changes                                | 2 = unhealthy                          | Score |
|----------------|--------------------------|--------------------------------------------|----------------------------------------|-------|
| Lips           | Smooth, Pink, Moist      | Dry, chapped, red at corners               | Swelling or lump                       |       |
| 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, Swollen, bleeding |       |
| Saliva         | Moist Tissues, Watery    | Dry, sticky tissues, little saliva present | 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                     |       |

