



# DENTISTREE DENTAL CLINIC

File No:

5192

|                           |                                                                                                                                                 |        |                                                 |                     |
|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--------|-------------------------------------------------|---------------------|
| Name:                     | AYDEN                                                                                                                                           |        |                                                 |                     |
| Mobile no.:               | 0566432495                                                                                                                                      | Email: | niloo farfathuma@gmail.com                      |                     |
| Date of Birth:            | 23/12/16                                                                                                                                        | Sex:   | <input type="radio"/> M <input type="radio"/> F | Nationality: INDIAN |
| How do you know about us? | <input type="radio"/> Family or Friends <input type="radio"/> Internet <input type="radio"/> Newspapers <input checked="" type="radio"/> Others |        |                                                 |                     |

## MEDICAL HISTORY

Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

Chief Complaint: Molaculusion

| All details will be strictly confidential.                      | Yes                                 | No                                  | Others, Please Specify      |
|-----------------------------------------------------------------|-------------------------------------|-------------------------------------|-----------------------------|
| Are you under a physician's care now?                           |                                     | <input checked="" type="checkbox"/> |                             |
| Are you taking any medications, pills, or drugs?                | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Inhalation steroids         |
| Have you ever been hospitalized or had a major operation?       | <input checked="" type="checkbox"/> |                                     | Acute asthma, Adenoids surg |
| Have you ever had any complications following dental treatment? |                                     | <input checked="" type="checkbox"/> |                             |
| Are you a smoker?                                               |                                     | <input checked="" type="checkbox"/> |                             |

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

|                                                          |                                                       |                                          |                                              |
|----------------------------------------------------------|-------------------------------------------------------|------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Low Blood Pressure           | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting / Seizures |
| <input checked="" type="checkbox"/> Asthma               | <input type="checkbox"/> Heart Attack                 | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Leukemia            |
| <input type="checkbox"/> Heart Disease                   | <input type="checkbox"/> Kidney Disease               | <input type="checkbox"/> Liver Disease   | <input type="checkbox"/> Lung Disease        |
| <input type="checkbox"/> Thyroid Problem                 | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Hepatitis/Jaundice  |
| <input type="checkbox"/> Stroke                          | <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Cancer          | <input type="checkbox"/> AIDS/HIV Infection  |
| <input type="checkbox"/> Creutzfeldt-Jakob disease (CJD) | <input type="checkbox"/> Others, Please Specify _____ |                                          |                                              |

| Are you allergic, or have you reacted adversely to any of the following: | Yes | No                                  | Others, Please Specify |
|--------------------------------------------------------------------------|-----|-------------------------------------|------------------------|
| Local anesthetics (Novocaine)                                            |     | <input checked="" type="checkbox"/> |                        |
| Penicillin or other antibiotics                                          |     | <input checked="" type="checkbox"/> |                        |
| Asperin or Ibuprofen                                                     |     | <input checked="" type="checkbox"/> |                        |
| Reactions to metals                                                      |     | <input checked="" type="checkbox"/> |                        |
| Latex or rubber dam                                                      |     | <input checked="" type="checkbox"/> |                        |
| Foods                                                                    |     | <input checked="" type="checkbox"/> |                        |

| 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

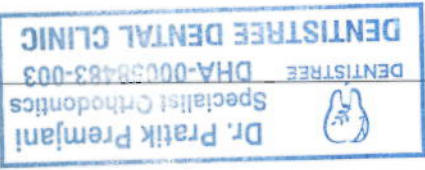
|              |                          |                           |                         |                         |                      |
|--------------|--------------------------|---------------------------|-------------------------|-------------------------|----------------------|
|              |                          |                           |                         |                         |                      |
| 0<br>NO HURT | 2<br>HURTS<br>LITTLE BIT | 4<br>HURTS<br>LITTLE MORE | 6<br>HURTS<br>EVEN MORE | 8<br>HURTS<br>WHOLE LOT | 10<br>HURTS<br>WORST |

✓ No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Moderate 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 : 14/06/25  
Dentist Stamp :



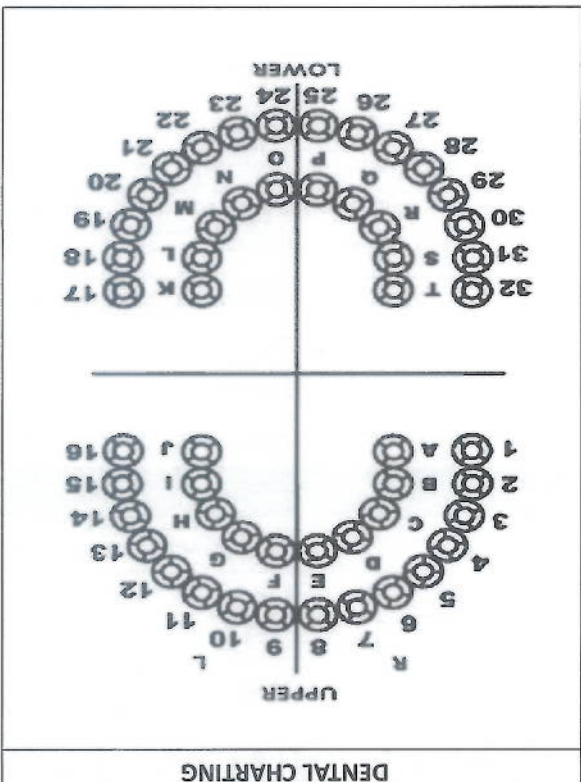
**YOUR FALL RISK** →

## FALL RISK ASSESSMENT

| Falls are common for 65yrs of age and older.               |   | Points | Yes                      | No                       |
|------------------------------------------------------------|---|--------|--------------------------|--------------------------|
| Do you fall in the past 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"/> |
| Total Points                                               |   | 14     | <input type="checkbox"/> | <input type="checkbox"/> |

| Category      | Lips                                           | Tongue                                            | Gums & Tissues                       | Saliva                                   | Natural Teeth                    | Denture(s)         |
|---------------|------------------------------------------------|---------------------------------------------------|--------------------------------------|------------------------------------------|----------------------------------|--------------------|
| 0 = healthy   | Smooth, Pink, Moist                            | Normal, Moist, Pink                               | Pink, Moist, Smooth                  | Moist Tissues, Watery                    | No Decayed/ Broken Teeth         | No Broken Areas    |
| 1 = changes   | Dry, chapped, red at corners, Swelling or lump | Patchy, fissured, red, coated, ulcerated, swollen | Dry, shiny, rough, Swollen, bleeding | No saliva present, Little saliva present | 1 to 3 decayed/ 1 broken teeth   | 1 Broken Area      |
| 2 = unhealthy | Swelling or lump                               | Patch that is red & ulcerated, swollen            | Generalized redness                  | Tissues parched                          | 4 or more decayed & broken teeth | More than 1 broken |
| Score         |                                                |                                                   |                                      |                                          |                                  |                    |

| 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"/> |