



# DENTISTREE DENTAL CLINIC

File No:

S269

Name: Mahmood Poormohammad.

Mobile no.: 9558181506

Email:

Date of Birth: 23/11/1975

Sex: ☒ M ☐ F

Nationality: Iran

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

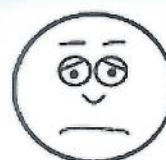
Others, Please Specify

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 HURT2  
HURTS  
LITTLE BIT4  
HURTS  
LITTLE MORE6  
HURTS  
EVEN MORE8  
HURTS  
WHOLE LOT10  
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.

Dentist Stamp :

Dr. Hengameh Shadafzah  
General Dentist  
DENTISTREE DHA-77225976-004  
DENTISTREE DENTAL CLINIC



**YOUR FALL RISK** ←

| 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"/> | <input type="checkbox"/> |
| Are you using or advice to use cane or walker?             | 2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you lose a balance while walking?                      | 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| You Worry about falling?                                   | 1 | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| Do you have trouble stepping up onto a crub/steps?         | 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you sways when standing stationary?                    | 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you take short narrow step?                             | 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you stamble often or look at the ground when you walk? | 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you frequently have to rush to the toilet?              | 1 | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| Do you take any medication to feel light headed or sleepy? | 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Total Points                                               |   | 14                       | <input type="checkbox"/> | <input type="checkbox"/> |

## FALL RISK ASSESSMENT

|                |                          |                                            |                                        |       |
|----------------|--------------------------|--------------------------------------------|----------------------------------------|-------|
| Category       | 0 = healthy              | 1 = changes                                | 2 = unhealthy                          | Score |
| Lips           | Smooth, Pink, Moist      | Dry, chapped, red at corners               | Swelling or lump ulcerated at corners  |       |
| Tongue         | Normal, Moist, Pink      | Patchy, fissured, red, coated              | Patch that is red & ulcerated, swollen |       |
| Gums & Tissues | Pink, Moist, Smooth      | Dry, shiny, rough, swollen 1 to 6 teeth    | Swollen, bleeding Generalized redness  |       |
| Saliva         | Moist Tissues, Watery    | Dry, sticky tissues, Little saliva present | No saliva present Tissues parched      |       |
| 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                     |       |

| Health information for TMJ                                              |                          | Yes                      | No |
|-------------------------------------------------------------------------|--------------------------|--------------------------|----|
| Do you clench or grind your jaws frequently?                            | <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"/> |    |

| <b>Oral Health Information Adult</b> |                                              |
|--------------------------------------|----------------------------------------------|
| <input checked="" type="checkbox"/>  | Do you gag easily?                           |
| <input checked="" type="checkbox"/>  | Do you wear dentures?                        |
| <input checked="" type="checkbox"/>  | Does food catch between your teeth?          |
| <input checked="" type="checkbox"/>  | Do you have difficulty in chewing your food? |
| <input checked="" type="checkbox"/>  | Do you chew on only one side of your mouth?  |
| <input checked="" type="checkbox"/>  | Do your gums bleed easily?                   |
| <input checked="" type="checkbox"/>  | Do your gums bleed when you floss?           |
| <input checked="" type="checkbox"/>  | Do your gums feel swollen or tender?         |
| <input checked="" type="checkbox"/>  | Are your teeth sensitive?                    |
| <input checked="" type="checkbox"/>  | Do you take fluoride supplements?            |
| <input checked="" type="checkbox"/>  | Do you prefer to save your teeth?            |
| <input checked="" type="checkbox"/>  | Do you want complete dental care?            |