



Name: <u>Majjan Reblee</u>			
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Date of Birth: <u>7 Aug 1994</u>		Sex: ☐ M ☒ F	Nationality: <u>Iranian</u>
How do you know about us? ☒ Family or Friends ☐ Internet ☐ Newspapers ☐ Others			

MEDICAL HISTORY

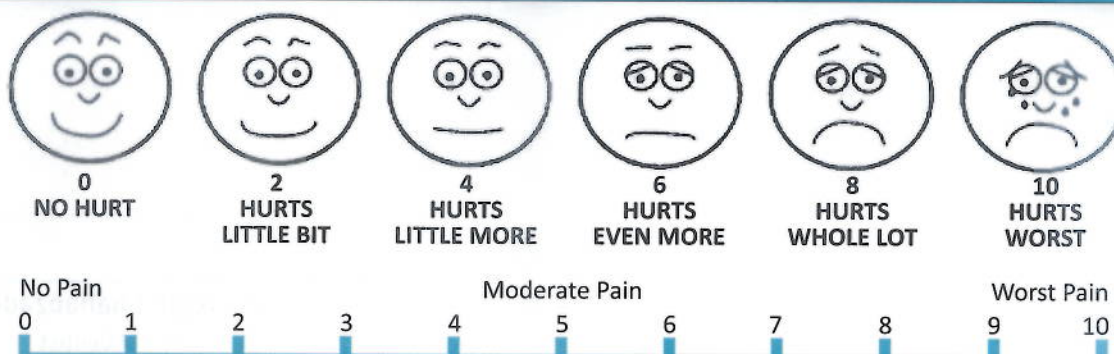
Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

Chief Complaint: _____

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



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 : 10/07/25
Dentist Stamp :

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



YOUR FALL RISK

FALL RISK ASSESSMENT

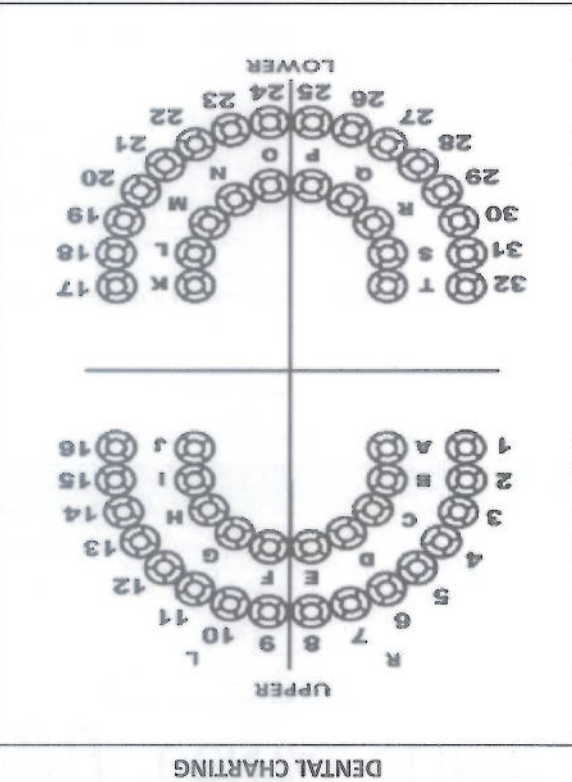
Points		Total Points	
No	Yes	14	
☐	☐	1	Do you take any medication to feel light headed or sleepy?
☐	☐	1	Do you have lost some feeling in one or both of your feet?
☐	☐	1	Do you frequently have to rush to the toilet?
☐	☐	1	Are you stumble often or look at the ground when you walk?
☐	☐	1	Do you take short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

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 thoothpase with flouride 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?

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, ulcerated at corners	Patchy, fissured, red, coated	Dry, shiny, rough, Swollen, bleeding	Dry, sticky tissues, No saliva present	1 to 3 decayed/ 1 broken teeth	1 Broken Area
2 = unhealthy	Swelling or lump	Swelling, ulcerated, swollen	Generalized redness	No saliva present	4 or more decayed & broken teeth	More than 1 broken
Score						



DENTAL CHARTING