



DENTISTREE DENTAL CLINIC

File No:

5312

Name: Ava GolestanehMobile no.: 0507489587

Email:

Date of Birth: 2011/7/27Sex: ☐ M ☒ FNationality: Saint Kitts and Nevis

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

☒☐Spry Food

Additional questions for women.

Yes

No

Others, Please Specify

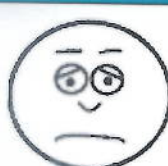
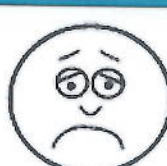
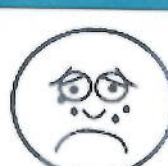
Are you pregnant or trying to get pregnant?

☒

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

0

1

2

3

4

5

6

7

8

9

10

Moderate Pain

Worst 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 : 14/07/25
Dentist Stamp :

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



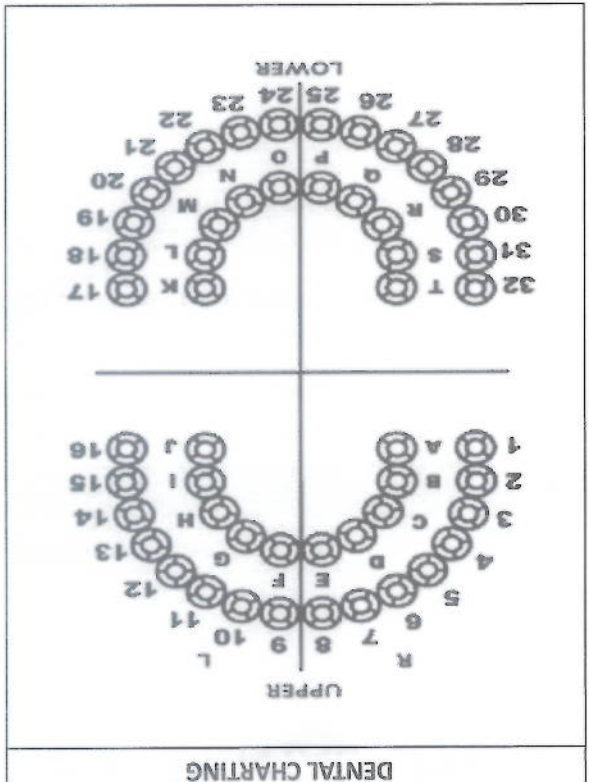
YOUR FALL RISK →

Falls are common for 65yrs of age and older.	Points	Yes	No
Do you fallen in the pass years?	2	☐	☐
Are you using or advice to use cane or walker?	2	☐	☐
Are you lose a balance while walking?	1	☐	☐
You Worry 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 curb/steps?	1	☐	☐
Are you sways when standing stationary?	1	☐	☐
Do you take short narrow step?	1	☐	☐
Are you stumble 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	☐	☐

FALL RISK ASSESSMENT

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	Patchy, fissured, red, coated	Dry, shiny, rough, swollen 1 to 6 teeth	No saliva present	1 to 3 decayed / 1 broken teeth	1 Broken Area
2 = unhealthy	Swelling or lump ulcerated at corners	Patch that is red & ulcerated, swollen	Swollen, bleeding 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?	☐	☐
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?	☒	☐