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|---------------------------------------|---|------------------------------------|----------------------------------|---|
| Name: <u>DAEHYUN KIM</u> | Mobile no.: <u>055-775-0177</u> | Email: <u>daytripbox@gmail.com</u> | | |
| Date of Birth: <u>18th. MAR. 1980</u> | Sex: <input checked="" type="radio"/> M <input type="radio"/> F | Nationality: <u>S. KOREAN</u> | | |
| 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: _____

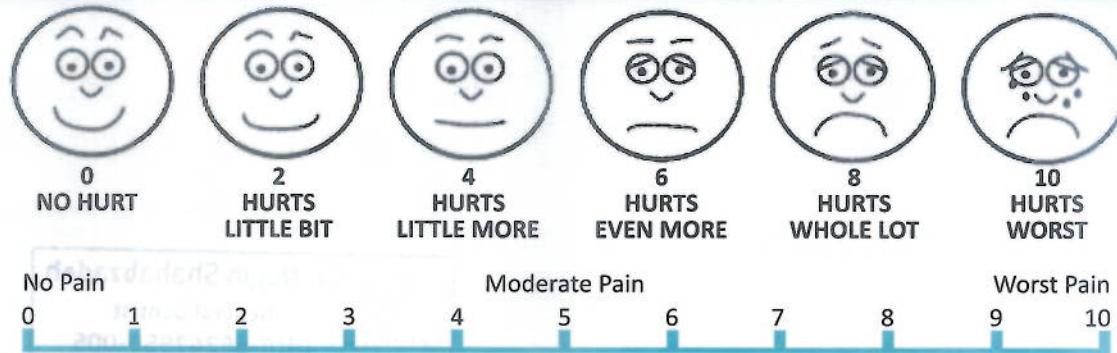
| All details will be strictly confidential. | Yes | No | Others, Please Specify |
|---|-----|----|------------------------|
| Are you under a physician's care now? | | ✓ | |
| Are you taking any medications, pills, or drugs? | | ✓ | |
| Have you ever been hospitalized or had a major operation? | | ✓ | |
| Have you ever had any complications following dental treatment? | | ✓ | |
| Are you a smoker? | ✓ | | |

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

| | | | |
|--|---|--|--|
| <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) | | ✓ | |
| 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



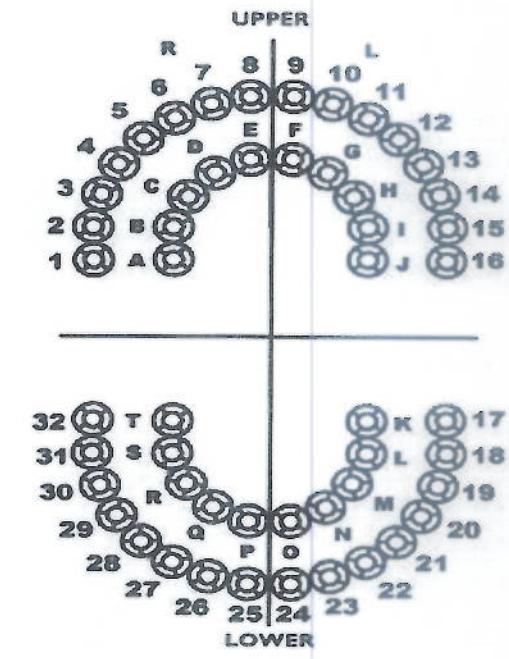
To the best of my knowledge, all of the preceding answer and information provided are true and correct.

If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

PATIENT ASSESSMENT FORM

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

DENTAL CHARTING



| 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"/> |

| 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"/> |

| 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 | |

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"/> |
| | 14 | <input type="checkbox"/> | <input type="checkbox"/> |
| Total Points | | | |

YOUR
FALL RISK →



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