



DENTISTREE DENTAL CLINIC

File No:

5492

Name:	Monika Shewakramani		
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Date of Birth:	03/10/94	Sex:	☐ M ☒ F
		Nationality:	Indian
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: Whitening

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?		☒	

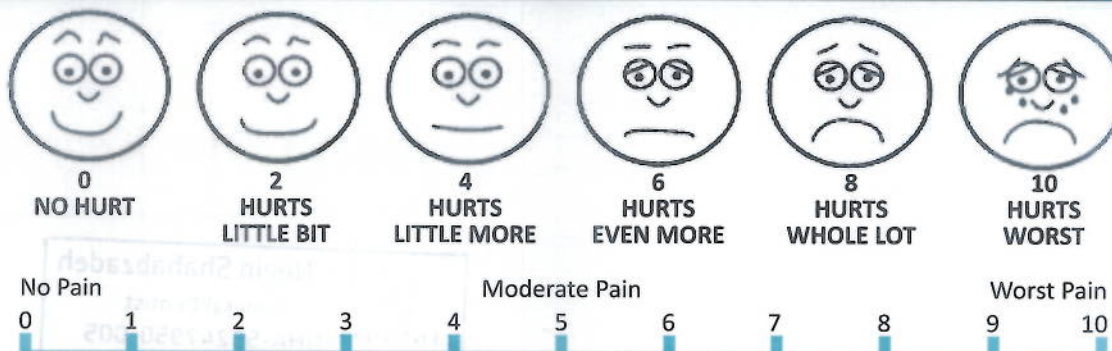
Do you have, or have you had any of the following

☐ 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	☒	☒	<u>Aluten</u>

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.

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?		☐	☐

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	Patchy, fissured, red, coated	Dry, shiny, rough, swollen 1 to 6 teeth	Dry, sticky tissues, Little 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	No saliva present Tissues parched	4 or more decayed & broken teeth	More than 1 broken
Score						

Oral Health Information Adult		Oral Health Information Pediatric/Child	
Do you gag easily?	☒ Yes ☐ No	Does your child use a toothpaste with fluoride in it?	☐ Yes ☐ No
Do you wear dentures?	☒ Yes ☐ No	Do you help your child with toothbrushing?	☐ Yes ☐ No
Does food catch between your teeth?	☒ Yes ☐ No	Have your child experience in a dental treatment?	☐ Yes ☐ No
Are your teeth sensitive?	☒ Yes ☐ No	Have your child ever had cavities?	☐ Yes ☐ No
Do your gums feel swollen or tender?	☒ Yes ☐ No	Does your child complain of mouth pain?	☐ Yes ☐ No
Do your gums bleed when you floss?	☒ Yes ☐ No	Does your child take a bottle to bed?	☐ Yes ☐ No
Do your gums bleed easily?	☒ Yes ☐ No	Does your child loves to eat foods like Chocolates, candy, snacks a lot?	☐ Yes ☐ No
Do you chew on only one side of your mouth?	☒ Yes ☐ No		

DENTAL CHARTING