DENTISTREE DENTAL CLINIC

File no: 517

Name: POONAM. RAJKUMAR			
Mobile no.: 0507844694.	**Email:** poonamrajkumar05@gmail.com		
Date of Birth: 5/2/69	**Sex:** o M ✓F	**Nationality:** INDIAN.	
How do you know about us? ✓ Family or Friends	o Internet	o Newspapers	o 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?	✓		Thyroxin 25mg
Have you ever been hospitalized or had a major operation?	✓		Demithyroidectomy
Have you ever had any complications following dental treatment?		✓	
Are you a smoker?		✓	

Do you have, or have you had any of the following None.

○ 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)		✓	Blood Group.
Penicillin or other antibiotics		✓	Beta Thalasemia
Asperin or Ibuprofen		✓	Trait
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.

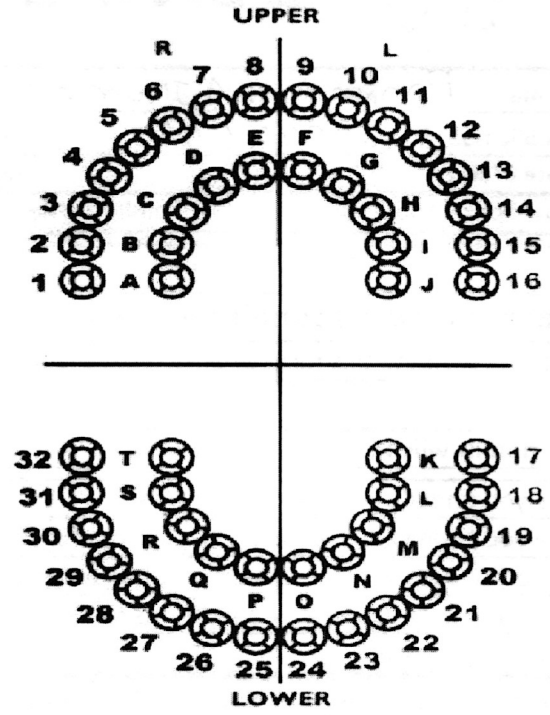
Signature of Patient, Parent or Guardian Date

PATIENT ASSESSMENT FORM

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?	☐	☐

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 experince 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?	☐	☐

Dental Charting



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?	☐	☑

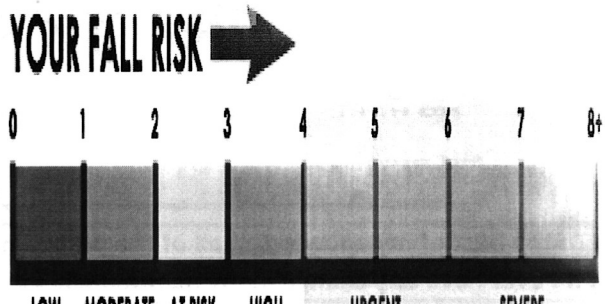
Category	0 = healthy	1 = changes	2 = unhealthy	Score
Lips	Smooth, pink, moist	Dry, chapped, or red at corners	Swelling or lump ulcerated at corners	
Tongue	Normal, moist, pink	Patchy, fissured, red, coated	Patch that is red and ulcerated, swollen	
Gums and Tissues	Pink, moist, Smooth	Dry, shiny, rough, swollen 1 to 3 teeth	Swollen, bleeding generalized redness	
Saliva	Moist tissues, watery	Dry, sticky tissues little saliva present	no saliva present Tissues parched	
Natural Teeth	No decayed or broken teeth	1 to 3 decayed or 1 broken teeth	4 or more decayed and broken teeth	
Denture(s)	No broken areas	1 broken area	More than 1 broken	

Oral Cleanliness ☐ Good ☐ Fair ☐ Poor

FALL RISK ASSESSMENT

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 crub/steps?	1	☐	☐
Are you sways when standing stationary?	1	☐	☐
Do you take short narrow step?	1	☐	☐
Are you stamble 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	☐	☐
	14		
Total Points			

If Your Scored 4 Points or more, You are Risk for Fall



Dr. Shruti Bhandari
General Dentist