



DENTISTREE DENTAL CLINIC

File no: _____

Name: ZARI

Mobile no.:

Email: ndavalu@mail.zu.

Date of Birth: 16.01.2000

Sex: M F

Nationality:

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? NO

Have you ever been hospitalized or had a major operation? NO

Have you ever had any complications following dental treatment? NO

Are you a smoker? NO

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

- | | | | |
|-------------------------------------------------------|----------------------------------------------------|---------------------------------------|-------------------------------------------|
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Rheumatic Fever | <input type="radio"/> Fainting / Seizures |
| <input type="radio"/> Asthma | <input type="radio"/> Heart Attack | <input type="radio"/> Epilepsy | <input type="radio"/> Leukemia |
| <input checked="" type="radio"/> Heart Disease | <input type="radio"/> Kidney Disease | <input type="radio"/> Liver Disease | <input type="radio"/> Lung Disease |
| <input type="radio"/> Thyroid Problem | <input type="radio"/> Diabetes | <input type="radio"/> Tuberculosis | <input type="radio"/> Hepatitis/Jaundice |
| <input type="radio"/> Stroke | <input type="radio"/> Arthritis | <input type="radio"/> Cancer | <input type="radio"/> AIDS/HIV Infection |
| <input type="radio"/> Creutzfeldt-Jakob disease (CJD) | <input type="radio"/> Others, Please Specify _____ | | |

Are you allergic, or have you reacted adversely to any of the following:

Yes No Others, Please Specify

Local anesthetics (Novocaine) NO

Penicillin or other antibiotics NO

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? NO

if yes, expected delivery date: _____

Are you taking oral contraceptives? _____

Please select the number that best represents your current pain intensity



0
NO HURT



2
HURTS
LITTLE BIT



4
HURTS
LITTLE MORE



6
HURTS
EVEN MORE



8
HURTS
WHOLE LOT



10
HURTS
WORST

No pain

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.

Signature of Patient, Parent or Guardian

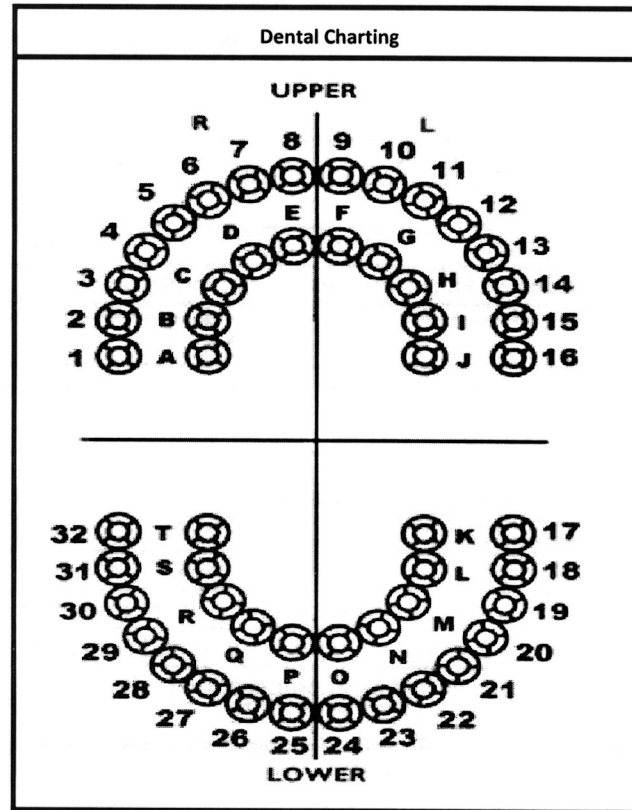
Date

PATIENT ASSESSMENT FORM

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

Oral Health Information Pediatric/Child	YES	NO
Does your child use a toothpaste with flouride in it?	<input type="checkbox"/>	<input type="checkbox"/>
Do you help your child with toothbrushing?	<input type="checkbox"/>	<input type="checkbox"/>
Have your child experince 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, 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 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 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.			
Do you fallen in the pass years?	Points	YES	NO
Are you using or advice to use cane or walker?	2	<input type="checkbox"/>	<input type="checkbox"/>
Are you lose a balance while walking?	2	<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 crub/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 stamble 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"/>
Total Points	14		

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

YOUR FALL RISK ➔

0

1

2

3

4

5

6

7

8+

LOW
MODERATE
AT RISK
HIGH
URGENT
SEVERE