



|                                                                                                                                                                           |                                                                 |                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------|--|
| Name: <u>Mukesh Kodnani</u>                                                                                                                                               |                                                                 |                            |  |
| Mobile no.: <u>055-2786740</u>                                                                                                                                            |                                                                 | Email:                     |  |
| Date of Birth:                                                                                                                                                            | Sex: <input checked="" type="radio"/> M <input type="radio"/> F | Nationality: <u>Indian</u> |  |
| How do you know about us? <input checked="" type="radio"/> Family or Friends <input type="radio"/> Internet <input type="radio"/> Newspapers <input type="radio"/> Others |                                                                 |                            |  |

### MEDICAL HISTORY

Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

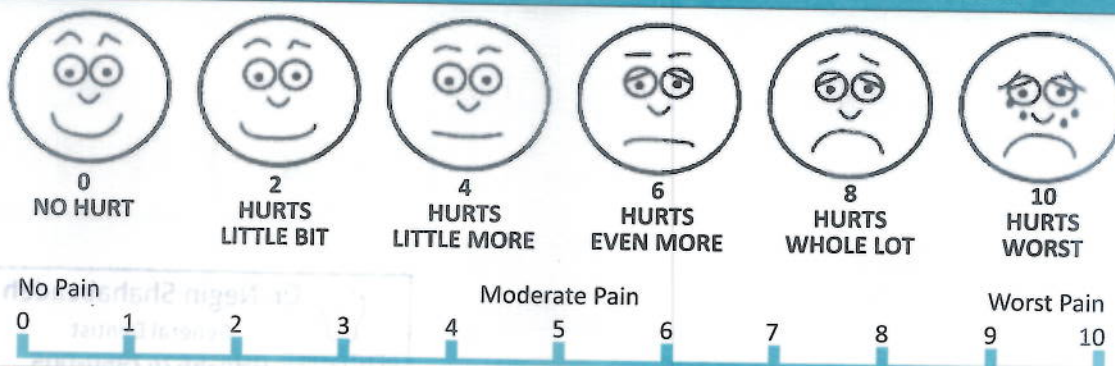
Chief Complaint: \_\_\_\_\_

| All details will be strictly confidential.                      |                                                       | Yes                                      | No                                           | Others, Please Specify |
|-----------------------------------------------------------------|-------------------------------------------------------|------------------------------------------|----------------------------------------------|------------------------|
| Are you under a physician's care now?                           |                                                       |                                          | <input checked="" type="checkbox"/>          |                        |
| Are you taking any medications, pills, or drugs?                |                                                       |                                          | <input checked="" type="checkbox"/>          |                        |
| Have you ever been hospitalized or had a major operation?       |                                                       | <input checked="" type="checkbox"/>      |                                              |                        |
| Have you ever had any complications following dental treatment? |                                                       |                                          | <input checked="" type="checkbox"/>          |                        |
| 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 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)                                            |     | <input checked="" type="checkbox"/> |                        |
| Penicillin or other antibiotics                                          |     | <input checked="" type="checkbox"/> |                        |
| Asperin or Ibuprofen                                                     |     | <input checked="" type="checkbox"/> |                        |
| Reactions to metals                                                      |     | <input checked="" type="checkbox"/> |                        |
| Latex or rubber dam                                                      |     | <input checked="" type="checkbox"/> |                        |
| Foods                                                                    |     | <input checked="" type="checkbox"/> |                        |

| 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

27/09/2025

PATIENT ASSESSMENT FORM

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

| Oral Health Information Pediatric/Child                                  |                                                          |
|--------------------------------------------------------------------------|----------------------------------------------------------|
| Does your child use a toothpaste with fluoride in it?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you help your child with toothbrushing?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have your child experience in a dental treatment?                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have your child ever had cavities?                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does your child complain of mouth pain?                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does your child take a bottle to bed?                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does your child loves to eat foods like Chocolates, candy, snacks a lot? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does your child gums bleed easily?                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| Health Information for TMJ                                              |                                                          |
|-------------------------------------------------------------------------|----------------------------------------------------------|
| Do you clench or grind your jaws frequently?                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do your jaws ever feel tired?                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does your jaw get stuck so that you can't open freely?                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does it hurt when you chew or open wide to take a bite?                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have earaches or pain in front of the ears?                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any jaw headaches upon awaking in the morning?              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you find jaw pain or discomfort extremely frustrating/depressing?    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a temporomandibular (jaw) disorder (TMD)?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have pain in the face, cheeks, jaws, joints, throat, or temples? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you unable to open your mouth as far as you want?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you aware of an uncomfortable bite?                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you had a blow to the jaw (trauma)?                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you a habitual gum chewer or pipe smoker?                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| DENTAL CHARTING |  |
|-----------------|--|
|                 |  |

| Category       | 0 = healthy              | 1 = changes                                      | 2 = unhealthy                          | Score |
|----------------|--------------------------|--------------------------------------------------|----------------------------------------|-------|
| Lips           | Smooth, Pink, Moist      | Dry, chapped, red at corners, ulcerated, swollen | Swelling or lump                       |       |
| 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                      |       |
| 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"/>  |
| Total Points                                               | 14 <input type="checkbox"/> <input type="checkbox"/> |

**YOUR FALL RISK**

LOW 0 1 2 3 4 5 6 7 8+ SEVERE

URGENT HIGH

MODERATE AT RISK

**DENTISTREE DENTAL CLINIC**

General Dentist DHA-56247950-005

Dr. Negin Shahabzadeh

Dentist Stamp :

Date : 27/09/25

Shop 3, Wasi Port Views 8,  
Next to Hyatt Place,  
Al Mina Road, Jumeirah 1, Dubai  
United Arab Emirates