



Name: <u>Sayed Hasan Sayed Yousef</u>			
Mobile no.:		Email:	
Date of Birth:		Sex: ☒ M ☐ F	Nationality: <u>Afghanistan</u>
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?			
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			
Aspirin 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

0	2	4	6	8	10					
NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST					
No Pain			Moderate Pain		Worst Pain					
0	1	2	3	4	5	6	7	8	9	10

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

29/9/25

LOW

MODERATE

AT RISK

HIGH

URGENT

SEVERE

012345678+

YOUR FALL RISK

Falls are common for 65yrs of age and older.		Points	Yes	No
Do you fallen in the past 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 curb/steps?	1			
Are you sways when standing stationary?	1			
Do you take short narrow step?	1			
Are you stumble 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			
Total Points	14			

FALL RISK ASSESSMENT

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, Swelling or lump	Patchy, fissured, red, coated, ulcerated, swollen	Dry, shiny, rough, Swollen, bleeding	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	Generalized redness	No saliva present	4 or more decayed & broken teeth	More than 1 broken
Score						

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?		

DENTAL CHARTING

UPPER

LOWER

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

A B C D E F G H I J

17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32

K L M N O P Q R S T

Oral Health Information Pediatric/Child	Yes	No
Does your child use a toothpaste with fluoride in it?		
Do you help your child with toothbrushing?		
Have your child experience 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?		

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?		

PATIENT ASSESSMENT FORM