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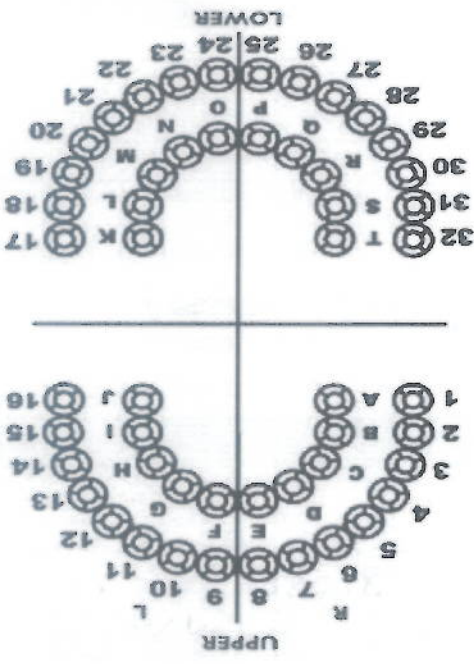
Signature of Patient, Parent or Guardian _____ Date 16-10-25

PATIENT ASSESSMENT FORM

Oral Health Information Adult	
Do you gag easily?	☒ Yes ☐ No
Do you wear dentures?	☒ Yes ☐ No
Does food catch between your teeth?	☒ Yes ☐ No
Do you have difficulty in chewing your food?	☒ Yes ☐ No
Do you chew on only one side of your mouth?	☒ Yes ☐ No
Do your gums bleed easily?	☒ Yes ☐ No
Do your gums bleed when you floss?	☒ Yes ☐ No
Do your gums feel swollen or tender?	☒ Yes ☐ No
Are your teeth sensitive?	☒ Yes ☐ No
Do you take fluoride supplements?	☒ Yes ☐ No
Do you prefer to save your teeth?	☒ Yes ☐ No
Do you want complete dental care?	☒ Yes ☐ No

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

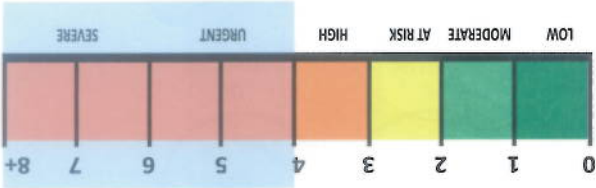
Health Information for TMJ	
Do you clench or grind your jaws frequently?	☐ Yes ☐ No
Do your jaws ever feel tired?	☐ Yes ☐ No
Does your jaw get stuck so that you can't open freely?	☐ Yes ☐ No
Does it hurt when you chew or open wide to take a bite?	☐ Yes ☐ No
Do you have earaches or pain in front of the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

DENTAL CHARTING	
	

Category	0 = healthy	1 = changes	2 = unhealthy	Score
Lips	Smooth, Pink, Moist	Dry, chapped, red at corners, ulcerated at corners	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 ☐ 2 ☐
Are you using or advice to use cane or walker?	2 ☐ 2 ☐
Are you lose a balance while walking?	1 ☐ 1 ☐
You Worry about falling?	1 ☐ 1 ☐
Do you use your arm/s to push your self from a chair?	1 ☐ 1 ☐
Do you have trouble stepping up onto a curb/steps?	1 ☐ 1 ☐
Are you sways when standing stationary?	1 ☐ 1 ☐
Do you take short narrow step?	1 ☐ 1 ☐
Are you stumble often or look at the ground when you walk?	1 ☐ 1 ☐
Do you frequently have to rush to the toilet?	1 ☐ 1 ☐
Do you have lost some feeling in one or both of your feet?	1 ☐ 1 ☐
Do you take any medication to feel light headed or sleepy?	1 ☐ 1 ☐
Total Points	14 ☐ 14 ☐

YOUR FALL RISK 



DENTISTREE DENTAL CLINIC
DHA-48302371-001
Specialist Endodontics
Dr. Roghith Kannan Mahesh

Dentist Stamp :
Date : 16/10/25

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