



Name:	SIRAJ SHAIKH		
Mobile no.:	0506545782	Email:	Shaiikh Siraj 7@gmail.com
Date of Birth:	07-01-1987	Sex:	☒ M ☐ F
How do you know about us?		Nationality:	INDIAN
☐ 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 <u>NONE</u>		
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		☒	
Asperin or Ibuprofen		☒	
Reactions to metals		☒	
Latex or rubber dam		☒	
Foods		☒	<u>NONE</u>
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 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					
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

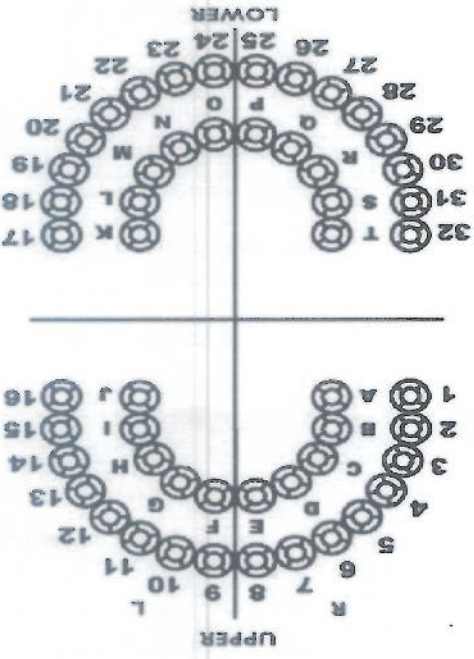
17/10/25

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
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	Lips	Tongue	Gums & Tissues	Saliva	Natural Teeth	Denture(s)
0 = healthy	Smooth, Pink, Moist	Normal, Pink, Moist	Pink, Moist, Smooth	Moist Tissues, Watery	No Decayed/ Broken Teeth	No Broken Areas
1 = changes	Dry, chapped, red at corners	Patchy, fissured, red, coated	Dry, shiny, rough, swollen 1 to 6 teeth	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	Swollen, bleeding Generalized redness	No saliva present Tissues parched	4 or more decayed & broken teeth	More than 1 broken
Score						

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 →

LOW MODERATE AT RISK HIGH URGENT SEVERE

0 1 2 3 4 5 6 7 8+

Dr. Akshaya Kulkarni
Specialist Oral and Maxillofacial Surgery
DHA-00148256-003
DENTISTREE DENTAL CLINIC

Dentist Stamp :

Date : 17/10/25

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