



Name: YU Zou				
Mobile no.: 058 232 7352		Email:		
Date of Birth: 14 FEB 1993		Sex: ☒ M ☐ F	Nationality: UK	
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.

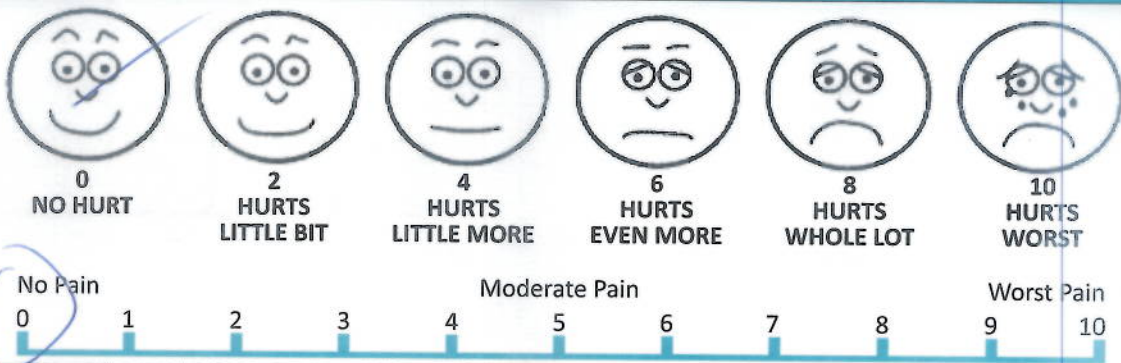
Chief Complaint:

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		☒	
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?		☒	
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: [Signature] Date: 24 OCT 2025

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 thoothpase with flouride 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

DENTAL CHARTING

UPPER

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

LOWER

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

Category	0 = healthy	1 = changes	2 = unhealthy	Score
Lips	Smooth, Pink, Moist	Dry, chapped, red at corners, swollen or lump	Swelling or lump	
Tongue	Normal, Pink, Moist	Patchy, fissured, red, coated, ulcerated, swollen	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	8, broken teeth	
Denture(s)	No Broken Areas	1 Broken Area	More than 1 broken	

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

FALL RISK ASSESSMENT

Falls are common for 65yrs of age and older.

Do you fallen in the pass years?

☐ 2 ☐ 1

Are you using or advice to use cane or walker?

☐ 2 ☐ 1

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 stamble 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 ☐ 13 ☐ 12 ☐ 11 ☐ 10 ☐ 9 ☐ 8 ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0

YOUR FALL RISK

LOW

MODERATE

AT RISK

HIGH

URGENT

SEVERE

0 1 2 3 4 5 6 7 8+

Dentist Stamp :

04/10/25

Date

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