



Name: SANDRA WONG			
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Date of Birth: 8/29/92	Sex: <input type="radio"/> M <input checked="" type="radio"/> F	Nationality: AMERICAN	
How do you know about us? <input type="radio"/> Family or Friends <input checked="" type="radio"/> Internet <input type="radio"/> Newspapers <input type="radio"/> Others			

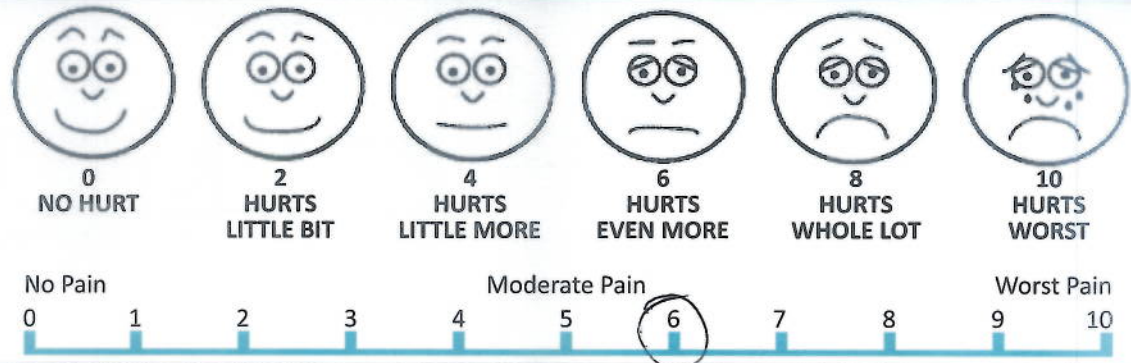
MEDICAL HISTORY

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?		X	
Are you taking any medications, pills, or drugs?		X	
Have you ever been hospitalized or had a major operation?		X	
Have you ever had any complications following dental treatment?		X	
Are you a smoker?		X	
Do you have, or have you had any of the following			
<input type="radio"/> High Blood Pressure	<input type="radio"/> Low Blood Pressure	<input type="radio"/> Rheumatic Fever	<input type="radio"/> Fainting / Seizures
<input type="radio"/> Asthma	<input type="radio"/> Heart Attack	<input type="radio"/> Epilepsy	<input type="radio"/> Leukemia
<input type="radio"/> Heart Disease	<input type="radio"/> Kidney Disease	<input type="radio"/> Liver Disease	<input type="radio"/> Lung Disease
<input type="radio"/> Thyroid Problem	<input type="radio"/> Diabetes	<input type="radio"/> Tuberculosis	<input type="radio"/> Hepatitis/Jaundice
<input type="radio"/> Stroke	<input type="radio"/> Arthritis	<input type="radio"/> Cancer	<input type="radio"/> AIDS/HIV Infection
<input type="radio"/> Creutzfeldt-Jakob disease (CJD)	<input type="radio"/> Others, Please Specify _____		
Are you allergic, or have you reacted adversely to any of the following:	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)		X	
Penicillin or other antibiotics		X	
Asperin or Ibuprofen		X	
Reactions to metals		X	
Latex or rubber dam		X	
Foods		X	
Additional questions for women.	Yes	No	Others, Please Specify
Are you pregnant or trying to get pregnant?		X	
if yes, expected delivery date: _____			
Are you taking oral contraceptives?		X	

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: 10/26/25



PATIENT ASSESSMENT FORM

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

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

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

DENTAL CHARTING

The diagram shows two dental arches. The upper arch is labeled 'UPPER' and contains teeth numbered 1 through 16. The lower arch is labeled 'LOWER' and contains teeth numbered 17 through 32. Each tooth is represented by a circle with a letter inside, corresponding to the FDI notation (e.g., 1 is A, 16 is J, 17 is K, 32 is T).

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

YOUR FALL RISK →

