



5716

Name: LEIGHTON SCOTT McDo nELL		
Mobile no.: 0382380137	Email: LMcDonnell47@icloud.com	
Date of Birth: 09/04/99	Sex: ☒ M ☐ F	Nationality: BRITISH
How do you know about us?	☐ Family or Friends ☒ Internet ☐ Newspapers	☐ Others

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?			NOPE

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

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 _____

02/11/25

PATIENT ASSESSMENT FORM

Oral Health Information Adult

☐	☐	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?

Oral Health Information Pediatric/Child

☐	☐	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?

Health Information for TMJ

☐	☐	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?

FALL RISK ASSESSMENT

☐	☐	Falls are common for 65yrs of age and older.
☐	☐	Do you fallen in the pass years?
☐	☐	Are you using or advice to use cane or walker?
☐	☐	Are you lose a balance while walking?
☐	☐	You Worry about falling?
☐	☐	Do you use your arm/s to push your self from a chair?
☐	☐	Do you have trouble stepping up onto a curb/steps?
☐	☐	Are you sways when standing stationary?
☐	☐	Do you take short narrow step?
☐	☐	Are you stamble often or look at the ground when you walk?
☐	☐	Do you frequently have to rush to the toilet?
☐	☐	Do you have lost some feeling in one or both of your feet?
☐	☐	Do you take any medication to feel light headed or sleepy?
☐	☐	Total Points
☐	☐	14

YOUR FALL RISK



Dr. Negin Shahbazadeh
General Dentist
DENTISTREE DHA-56247950-005
DENTISTREE DENTAL CLINIC

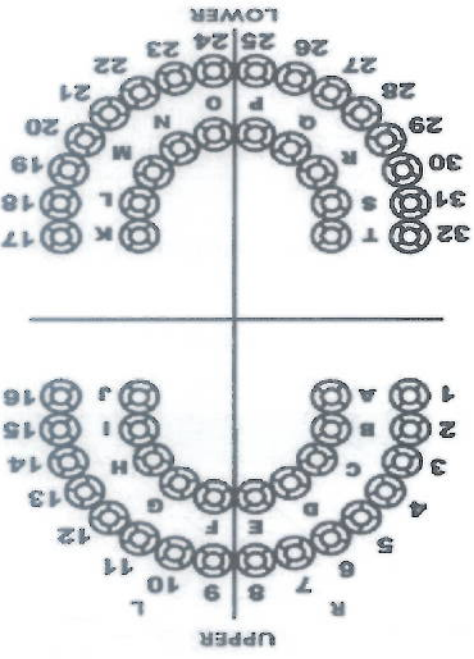
Dentist Stamp :

Date

02/11/2025

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

DENTAL CHARTING



Category	0 = healthy	1 = changes	2 = unhealthy	Score
Lips	Smooth, Pink, Moist	Dry, chapped, red at corners, Swelling or lump		
Tongue	Normal, Pink, Moist	Patchy, fissured, red, coated, ulcerated, swollen		
Gums & Tissues	Pink, Moist, Smooth	Dry, shiny, rough, 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	