



DENTISTREE DENTAL CLINIC

File No:

5927

Name: RISHU BHAGURATHY

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Email: rishi.bhagurath@gmail.com

Date of Birth: 17/10/1985

Sex: ☒ M ☐ F

Nationality: INDIAN

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?

☒☐

Blood pressure

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

☐☒

Aspirin or Ibuprofen

☐☒

Reactions to metals

☐☒

Latex or rubber dam

☐☒

Foods

☐☒

Shell fish

Additional questions for women.

Yes

No

Others, Please Specify

Are you pregnant or trying to get pregnant?

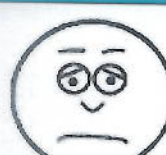
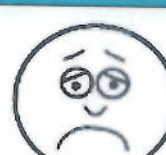
☐☐

if yes, expected delivery date:

Are you taking oral contraceptives?

☐☐

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY

0
NO HURT2
HURTS
LITTLE BIT4
HURTS
LITTLE MORE6
HURTS
EVEN MORE8
HURTS
WHOLE LOT10
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

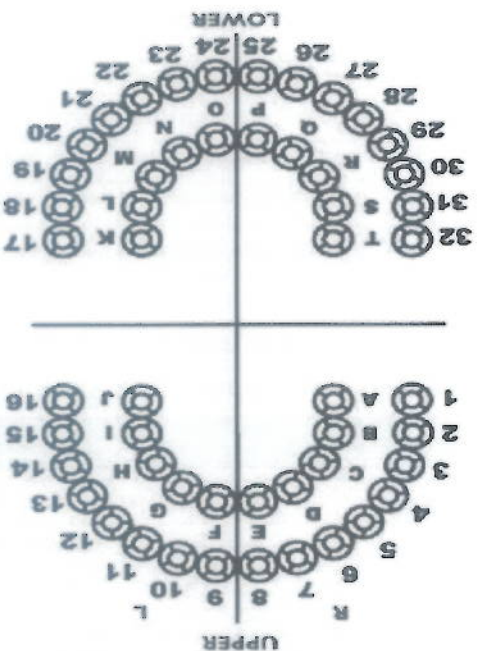
3/11/25

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

YOUR FALL RISK 

LOW MODERATE AT RISK HIGH URGENT SEVERE

0 1 2 3 4 5 6 7 8+

DENTISTREE DENTAL CLINIC

Dr. Roghith Kannan Mahesh

Specialist Endodontics

DENTISTREE DHA-48302371-001

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Next to Hyatt Place,
Al Mina Road, Jumeirah 1, Dubai
United Arab Emirates

Dentist Stamp :
Date : 04/11/25