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Name: <u>Faisal Esmat Al Lamimo</u>			
Mobile no.: <u>0561100511</u>		Email:	
Date of Birth: <u>28/06/2008</u>		Sex: ☒ M ☐ F	Nationality: <u>Jordan</u>
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?		☒	

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:

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.

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?			
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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 _____

16/11/25

FALL RISK ASSESSMENT

YOUR FALL RISK ←

Falls are common for 65yrs of age and older.		Points	Yes	No
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 crub/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				

Dr. Hengameh Shadatzah
 General Dentist
 DHA-77225976-004
 DENTISTREE DENTAL CLINIC

Health Information for TMJ		Yes	No
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?		☐	☐

Category	Lips	Tongue	Gums & Tissues	Saliva	Natural Teeth	Denture(s)
0 = healthy	Smooth, Pink, Moist	Normal, Moist, Pink	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						

Oral Health Information Adult		Oral Health Information Pediatric/Child	
☐	Do you gag easily?	☐	Does your child use a throatpase with flouride in it?
☐	Do you wear dentures?	☐	Do you help your child with toothbrushing?
☐	Does food catch between your teeth?	☐	Have your child experience in a dental treatment?
☐	Do you have difficulty in chewing your food?	☐	Have your child ever had cavities?
☐	Do you chew on only one side of your mouth?	☐	Does your child complain of mouth pain?
☐	Do your gums bleed easily?	☐	Does your child take a bottle to bed?
☐	Do your gums bleed when you floss?	☐	Does your Child loves to eat foods like Chocolates, candy, snacks a lot?
☐	Do your gums feel swollen or tender?	☐	Does your child gums bleed easily?
☐	Are your teeth sensitive?		
☐	Do you take fluoride supplements?		
☐	Do you prefer to save your teeth?		
☐	Do you want complete dental care?		

DENTAL CHARTING	