



Name: Hossein Mohammad Poor

Mobile no.: 0506395157

Email:

Date of Birth: 18/11/2009

Sex:

☒ M

☐ F

Nationality: Iran

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



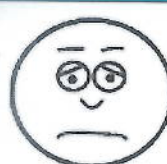
0
NO HURT



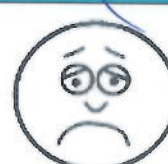
2
HURTS
LITTLE BIT



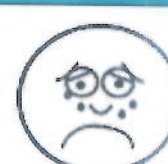
4
HURTS
LITTLE MORE



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

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, red at corners, swollen or lump	Dry, chapped, ulcerated at corners		
Tongue	Normal, Pink, 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	
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	☐ 2
Are you using or advice to use cane or walker?	☐ 2	☐ 2
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 stumble 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	

YOUR FALL RISK

