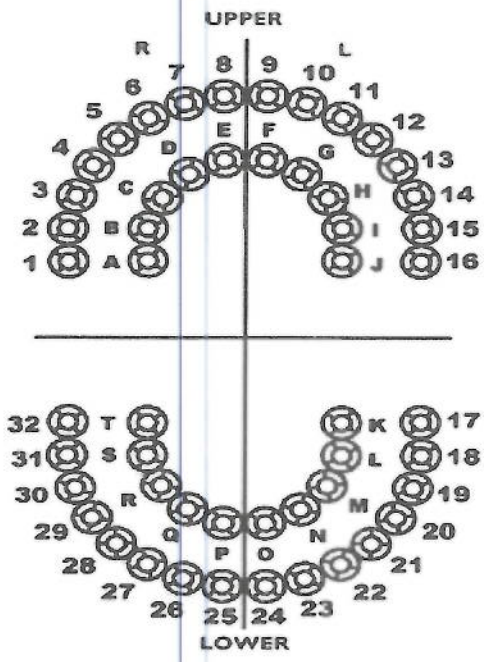
# PATIENT ASSESSMENT FORM

| Oral Health Information Adult | Yes | No |
|---|---|---|
| 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 | Yes | No |
|---|---|---|
| Does your child use a thoothpase with flouride in it? | ☐ | ☐ |
| Do you help your child with toothbrushing? | ☐ | ☐ |
| Have your child experince 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 | 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? | ☐ | ☐ |

## DENTAL CHARTING

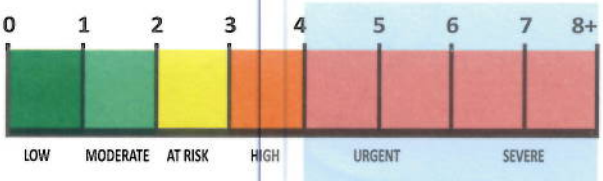



| Category | 0 = healthy | 1 = changes | 2 = unhealthy | Score |
|---|---|---|---|---|
| Lips | Smooth, Pink, Moist | Dry, chapped, red at corners | Swelling or lump ulcerated at corners | |
| Tongue | Normal, Moist, Pink | Patchy, fissured, red, coated | Patch that is red & ulcerated, swollen | |
| 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 crub/steps? | 1 | ☐ | ☐ |
| Are you sways when standing stationary? | 1 | ☐ | ☐ |
| Do you take short narrow step? | 1 | ☐ | ☐ |
| Are you stamble 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 | ☐ | ☐ |
| | 14 | ☐ | ☐ |
| Total Points | | | |

**YOUR FALL RISK** ➔

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