DENTISTREE DENTAL CLINIC

File No: 2984

Name:	SIRRI DUALLA		
Mobile no.:	0554570593	Email:	siri-ngome@icloud-com
Date of Birth:	05/07/96	Sex:	○ M ○F
Nationality:	Cameroonian		
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?	✓		Appendicitis
Have you ever had any complications following dental treatment?		✓	
Are you a smoker?	✓		Vapes

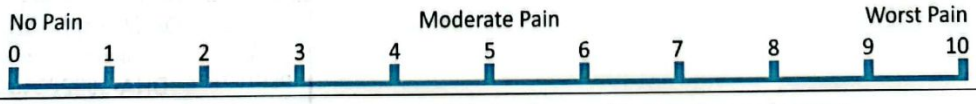
Do you have, or have you had any of the following

○ 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	✓		Walnuts.

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



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.

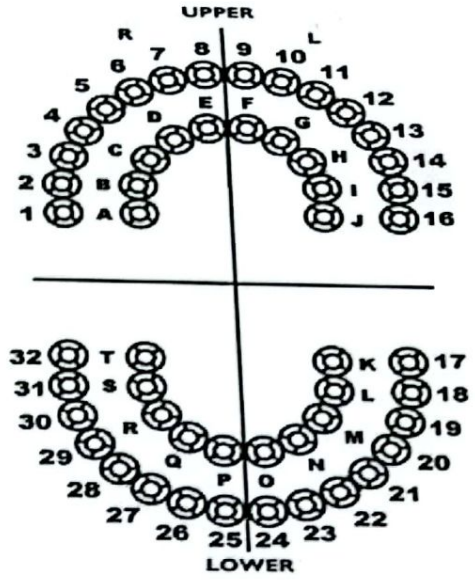
_____ 12.12.23

Signature of Patient, Parent or Guardian **Date**

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?	☒	☐

DENTAL CHARTING



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?	☐	☐

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 →

DENTISTREE
Dr. Mostafa Abdalla
General Dentist
DHA-00222048-001
DENTISTREE DENTAL CLINIC

op 3, Wasl Port Views 8,
xt to Hyatt Place,
Mina Road, Jumeirah 1, Dubai
ited Arab Emirates

Dentist Stamp :

Date : _____