

4433 File No: Veex Name: Sidhus Mobile no.: 0501045254 Email: preet-cheema @ hotmail. com Date of Birth: 07. 03. 22 Sex: O M Nationality: How do you know about us? Family or Friends ○ Internet Newspapers O 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. 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? X 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: No Others, Please Specify Local anesthetics (Novocaine) Penicillin or other antibiotics Asperin or Ibuprofen Reactions to metals Latex or rubber dam Foods No Additional questions for women. Yes d 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 **NO HURT HURTS HURTS HURTS** HURTS **HURTS** LITTLE BIT LITTLE MORE WHOLE LOT **EVEN MORE** WORST No Pain

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.

Moderate Pain

Worst Pain

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Oral Health Information Adult		Yes	No	
Do you gag easily?				
Do you wear dentures?				C
Does food catch between your teeth?				
Do you have difficulty in chewing your food?			6	
Do you chew on only one side of your mouth			6	1
Do your gums bleed easily?			1	1
Do your gums bleed when you floss?			1	
Do your gums feel swollen or tender?			1	1
Are your teeth sensitive?			0	1
Do you take fluoride supplements?			1	1
Do you prefer to save your teeth?		A		1
Do you want complete dental care?		d		1
	in it?	Yes	No	
Oral Health Information Pediatric/Child		Yes	No	
Does your child use a thoothpase with flouride	in it?		9	-
Do you help your child with toothbrushing?		니브	$\mathcal{L}$	
Have your child experince in a dental treatmer	1.7		4	
Have your child ever had cavities?			7	
Does your child complain of mouth pain?				
Does your child take a bottle to bed?			Ø	
Does your Child loves to eat foods like Chocola	es, 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 ta	ke a bite?			
Do you have earaches or pain in front of the ea	re?		П	1

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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 fustrating /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.	Poir	nts Ye	s N	0	0	
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			וכ	YOUR	
You Worry about falling?	1		] [		☐ FALL RISK →	
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				0 1 2 3 4 5 6 7 8+	
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				LOW MODERATE AT RISK HIGH URGENT SEVERE	
Do you take any medication to feel light headed or sleepy?	1			]		
	14	TE				
Total	Points					

Shop 3, Wasl Port Views 8, Next to Hyatt Place, Al Mina Road, Jumeirah 1, Dubai United Arab Emirates

Dr. Hashmit Kaur
Specialist Pediatric Dentistry
DENTISTREE DHA-00232915-006
DENTISTREE DENTAL CLINIC

Date