



DENTISTREE DENTAL CLINIC

File No:

4988

Name:	MEERA MENON PATHIYIL		
Mobile no.:	055-2209656	Email:	menonmeera8@gmail.com
Date of Birth:	22/08/1989	Sex:	☐ M ☒ F
How do you know about us?		Nationality:	
☐ Family or Friends		☐ Internet	☐ Newspapers
☐ Others			

MEDICAL HISTORY

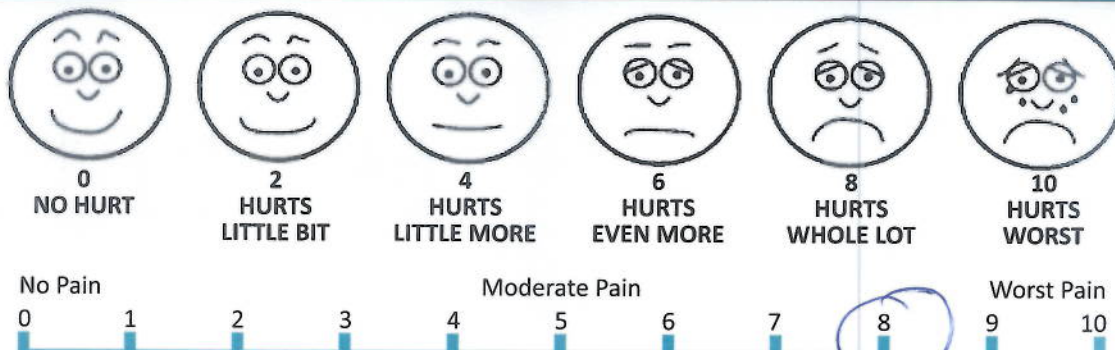
Certain medical conditions can affect dental treatment and vice versa.

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



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.

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 toothpaste with fluoride in it?		☐	☐
Do you help your child with toothbrushing?		☐	☐
Have your child experience 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

UPPER

LOWER

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	☐	☐
Total Points	14	☐	☐

YOUR FALL RISK →