



DENTISTREE DENTAL CLINIC

File No:

DR 6

Name:	Jayantilal Karkad				
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Date of Birth:	1.5.54	Sex:	<input checked="" type="radio"/> M <input type="radio"/> F	Nationality:	Indian
How do you know about us?	<input checked="" type="radio"/> Family or Friends	<input type="radio"/> Internet	<input type="radio"/> Newspapers	<input type="radio"/> Others	

MEDICAL HISTORY

Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

Chief Complaint: Toothache

All details will be strictly confidential.	Yes	No	Others, Please Specify
Are you under a physician's care now?		<input checked="" type="checkbox"/>	
Are you taking any medications, pills, or drugs?	<input checked="" type="checkbox"/>		
Have you ever been hospitalized or had a major operation?	<input checked="" type="checkbox"/>		
Have you ever had any complications following dental treatment?		<input checked="" type="checkbox"/>	
Are you a smoker?		<input checked="" type="checkbox"/>	
Do you have, or have you had any of the following			
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Fainting / Seizures
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Thyroid Problem	<input checked="" type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hepatitis/Jaundice
<input type="checkbox"/> Stroke	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> AIDS/HIV Infection
<input type="checkbox"/> Creutzfeldt-Jakob disease (CJD)	<input type="checkbox"/> Others, Please Specify _____		
Are you allergic, or have you reacted adversely to any of the following:	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)		<input checked="" type="checkbox"/>	
Penicillin or other antibiotics		<input checked="" type="checkbox"/>	
Asperin or Ibuprofen		<input checked="" type="checkbox"/>	
Reactions to metals		<input checked="" type="checkbox"/>	
Latex or rubber dam		<input checked="" type="checkbox"/>	
Foods		<input checked="" type="checkbox"/>	
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

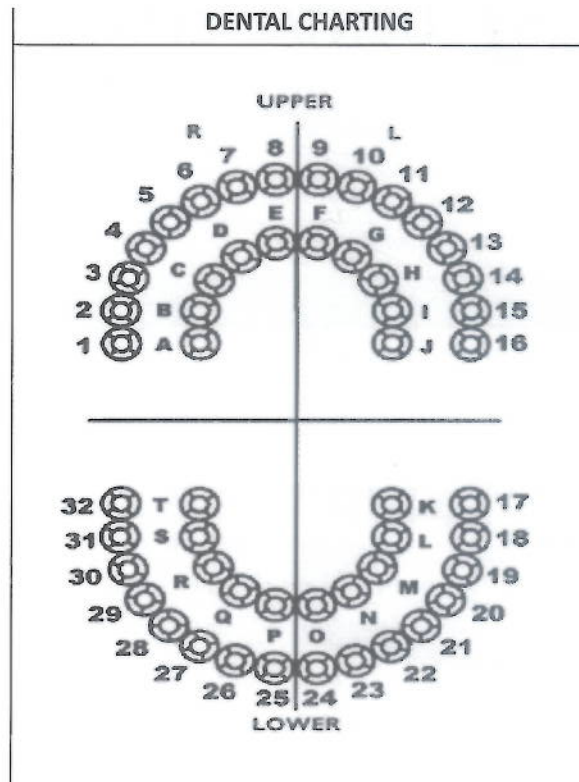
0 NO HURT	2 HURTS LITTLE BIT	4 HURTS LITTLE MORE	6 HURTS EVEN MORE	8 HURTS WHOLE LOT	10 HURTS WORST												
No Pain						Moderate Pain						Worst Pain					
0	1	2	3	4	5	6	7	8	9	10							

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.

Oral Health Information Adult		Yes	No
Do you gag easily?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty in chewing your food?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Do you take fluoride supplements?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Do you prefer to save your teeth?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Do you want complete dental care?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Oral Health Information Pediatric/Child		Yes	No
Does your child use a toothpaste with fluoride in it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you help your child with toothbrushing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have your child experience in a dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have your child ever had cavities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child complain of mouth pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child take a bottle to bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your Child loves to eat foods like Chocolates, candy, snacks a lot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child gums bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Health Information for TMJ		Yes	No
Do you clench or grind your jaws frequently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your jaws ever feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your jaw get stuck so that you can't open freely?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does it hurt when you chew or open wide to take a bite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have earaches or pain in front of the ears?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any jaw headaches upon awaking in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you find jaw pain or discomfort extremely frustrating /depressing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a temporomandibular (jaw) disorder (TMD)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you unable to open your mouth as far as you want?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of an uncomfortable bite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a blow to the jaw (trauma)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you a habitual gum chewer or pipe smoker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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	<input type="checkbox"/>	<input type="checkbox"/>
Are you using or advice to use cane or walker?	2	<input type="checkbox"/>	<input type="checkbox"/>
Are you lose a balance while walking?	1	<input type="checkbox"/>	<input type="checkbox"/>
You Worry about falling?	1	<input type="checkbox"/>	<input type="checkbox"/>
Do you use your arm/s to push your self from a chair?	1	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble stepping up onto a crub/steps?	1	<input type="checkbox"/>	<input type="checkbox"/>
Are you sways when standing stationary?	1	<input type="checkbox"/>	<input type="checkbox"/>
Do you take short narrow step?	1	<input type="checkbox"/>	<input type="checkbox"/>
Are you stamble often or look at the ground when you walk?	1	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently have to rush to the toilet?	1	<input type="checkbox"/>	<input type="checkbox"/>
Do you have lost some feeling in one or both of your feet?	1	<input type="checkbox"/>	<input type="checkbox"/>
Do you take any medication to feel light headed or sleepy?	1	<input type="checkbox"/>	<input type="checkbox"/>
	14	<input type="checkbox"/>	<input type="checkbox"/>
Total Points			

YOUR FALL RISK →

