



DENTISTREE DENTAL CLINIC

File No:

5047

Name: RISHAAN MANGANI

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Email: RISHAAN2711@GMAIL.COM

Date of Birth: 27/11/91

Sex: ☒ M ☐ F

Nationality: INDIAN

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?		☒	
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



No Pain

Moderate Pain

Worst 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.

Oral Health Information Adult

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?	☒	☐

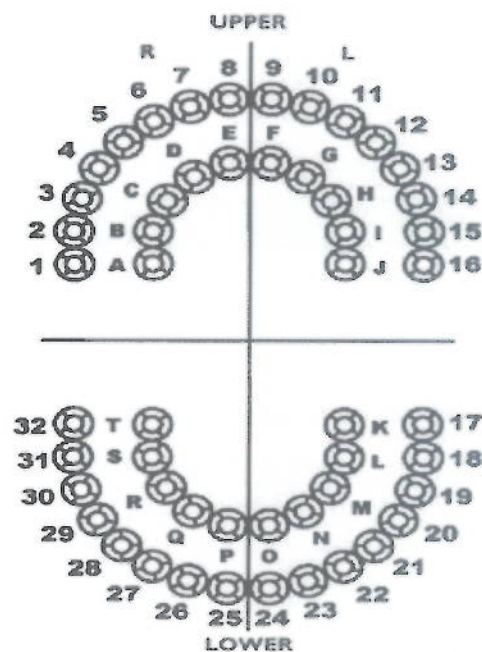
Oral Health Information Pediatric/Child

Yes	No
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐

Health Information for TMJ

Yes	No
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
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☐	☐
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☐	☐
☐	☐

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 →

