



DENTISTREE DENTAL CLINIC

File No:

5086

Name:	Kamala Phulwani				
Mobile no.:	050-5342833	Email:	VIKUMARPHULWANI @ GMAIL - COM		
Date of Birth:	11-06-1964	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: _____

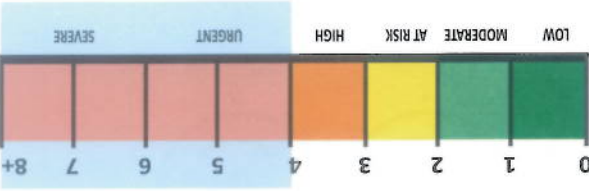
All details will be strictly confidential.	Yes	No	Others, Please Specify
Are you under a physician's care now?		☒	
Are you taking any medications, pills, or drugs?		☒	
Have you ever been hospitalized or had a major operation?		☒	
Have you ever had any complications following dental treatment?	☒		
Are 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



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.

Dr. Rutul Desai
General Dentist
DENTISTREE
DHA-44339326-001
DENTISTREE DENTAL CLINIC
Dentist Stamp



YOUR FALL RISK

FALL RISK ASSESSMENT

Points		Total Points	
No	Yes	14	
☐	☐	1	Do you take any medication to feel light headed or sleepy?
☐	☐	1	Do you have lost some feeling in one or both of your feet?
☐	☐	1	Do you frequently have to rush to the toilet?
☐	☐	1	Are you stumble often or look at the ground when you walk?
☐	☐	1	Do you take short narrow step?
☐	☐	1	Are you sways when standing stationary?
☐	☐	1	Do you have trouble stepping up onto a curb/steps?
☐	☐	1	Do you use your arm/s to push your self from a chair?
☐	☐	1	You Worry about falling?
☐	☐	1	Are you lose a balance while walking?
☐	☐	2	Are you using or advice to use cane or walker?
☐	☐	2	Do you fallen in the pass years?
No	Yes	Falls are common for 65yrs of age and older.	

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?

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?

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?

Category		Lips	Tongue	Gums & Tissues	Saliva	Natural Teeth	Denture(s)
0 = healthy	1 = changes	Smooth, Pink, Moist	Normal, Pink, Moist	Pink, Moist, Dry, shiny, rough, Swollen, bleeding	Moist Tissues, Watery, Little saliva present, No saliva present	No Decayed/ Broken Teeth	No Broken Areas
1 = changes	2 = unhealthy	Dry, chapped, red at corners, Swelling or lump	Patchy, fissured, red, coated, ulcerated, swollen	Swollen, bleeding, Generalized redness	Dry, sticky tissues, Little saliva present, No saliva present	1 to 3 decayed/ Broken teeth	1 Broken Area
2 = unhealthy	Score	ulcerated at corners	Patch that is red &			4 or more decayed & broken teeth	More than 1 broken

