



# DENTISTREE DENTAL CLINIC

File No:

5318

|                           |                                                                                                                                                 |        |                                                            |                     |
|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------------------------------------------------------|---------------------|
| Name:                     | WASTM ASKAR MOHAMED NOORJEEEN                                                                                                                   |        |                                                            |                     |
| Mobile no.:               | 056793554                                                                                                                                       | Email: | WASITME99@GMAIL.COM                                        |                     |
| Date of Birth:            | 18 MAY 1999                                                                                                                                     | 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

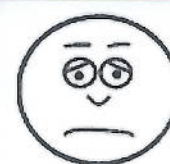
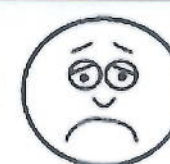
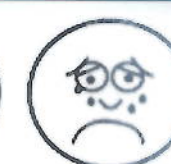
Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

Chief Complaint: \_\_\_\_\_

|                                                                                 |                                                    |                                       |                                           |
|---------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------|-------------------------------------------|
| <b>All details will be strictly confidential.</b>                               | 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"/>   |                                           |
| <b>Do you have, or have you had any of the following</b>                        |                                                    |                                       |                                           |
| <input type="radio"/> High Blood Pressure                                       | <input type="radio"/> Low Blood Pressure           | <input type="radio"/> Rheumatic Fever | <input type="radio"/> Fainting / Seizures |
| <input type="radio"/> Asthma                                                    | <input type="radio"/> Heart Attack                 | <input type="radio"/> Epilepsy        | <input type="radio"/> Leukemia            |
| <input type="radio"/> Heart Disease                                             | <input type="radio"/> Kidney Disease               | <input type="radio"/> Liver Disease   | <input type="radio"/> Lung Disease        |
| <input type="radio"/> Thyroid Problem                                           | <input type="radio"/> Diabetes                     | <input type="radio"/> Tuberculosis    | <input type="radio"/> Hepatitis/Jaundice  |
| <input type="radio"/> Stroke                                                    | <input type="radio"/> Arthritis                    | <input type="radio"/> Cancer          | <input type="radio"/> AIDS/HIV Infection  |
| <input type="radio"/> Creutzfeldt-Jakob disease (CJD)                           | <input type="radio"/> Others, Please Specify _____ |                                       |                                           |
| <b>Are you allergic, or have you reacted adversely to any of the following:</b> | 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"/>   |                                           |
| <b>Additional questions for women.</b>                                          | Yes                                                | No                                    | Others, Please Specify                    |
| Are you pregnant or trying to get pregnant?                                     |                                                    | <input checked="" type="checkbox"/>   |                                           |
| if yes, expected delivery date: _____                                           |                                                    |                                       |                                           |
| Are you taking oral contraceptives?                                             |                                                    |                                       |                                           |

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY

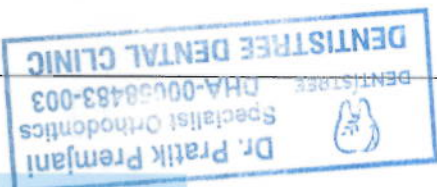
|                                                                                     |                                                                                     |                                                                                     |                                                                                     |                                                                                       |                                                                                       |   |   |   |   |    |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---|---|---|---|----|
|  |  |  |  |  |  |   |   |   |   |    |
| 0<br>NO HURT                                                                        | 2<br>HURTS<br>LITTLE BIT                                                            | 4<br>HURTS<br>LITTLE MORE                                                           | 6<br>HURTS<br>EVEN MORE                                                             | 8<br>HURTS<br>WHOLE LOT                                                               | 10<br>HURTS<br>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.

Dentist Stamp :

Date

16/07/25



**YOUR FALL RISK** →

## FALL RISK ASSESSMENT

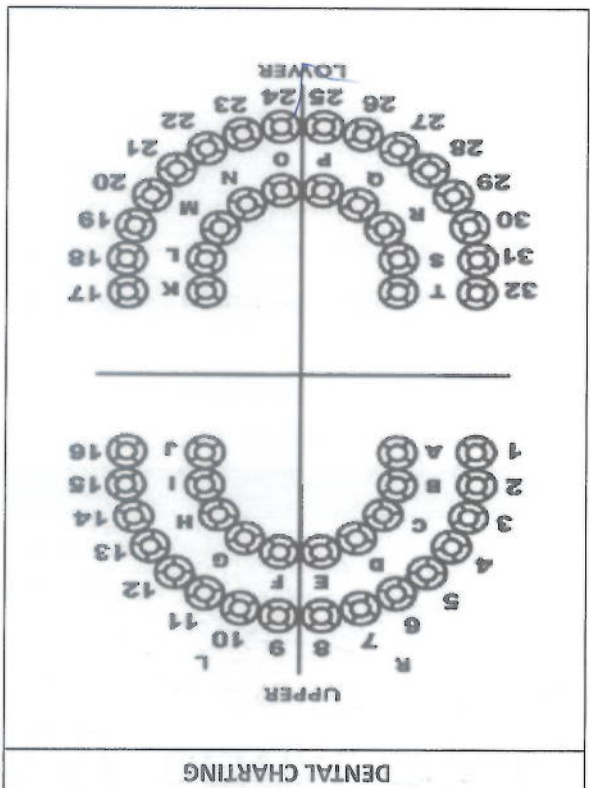
| Falls are common for 65yrs of age and older.               | Points | Yes                      | No                       | Total Points |
|------------------------------------------------------------|--------|--------------------------|--------------------------|--------------|
| Do you fall in the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

| Category       | 0 = healthy              | 1 = changes                                        | 2 = unhealthy                          | Score |
|----------------|--------------------------|----------------------------------------------------|----------------------------------------|-------|
| Lips           | Smooth, Pink, Moist      | Dry, chapped, red at corners, ulcerated at corners | Swelling or lump                       |       |
| 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                      |       |
| 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                     |       |

| Health Information for TMJ                                              | Yes                      | No                       |
|-------------------------------------------------------------------------|--------------------------|--------------------------|
| Do you clench or grind your jaws frequently?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your jaws ever feel tired?                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your jaw get stuck so that you can't open freely?                  | <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"/> |
| Do you have earaches or pain in front of the ears?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any jaw headaches upon awaking in the morning?              | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you find jaw pain or discomfort extremely frustrating/depressing?    | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a temporomandibular (jaw) disorder (TMD)?                   | <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"/> |
| Are you unable to open your mouth as far as you want?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you aware of an uncomfortable bite?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a blow to the jaw (trauma)?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you a habitual gum chewer or pipe smoker?                           | <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"/> |
| Do you help your child with toothbrushing?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Have your child experience in a dental treatment?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Have your child ever had cavities?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child complain of mouth pain?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child take a bottle to bed?                                    | <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"/> |
| Does your child gums bleed easily?                                       | <input type="checkbox"/> | <input type="checkbox"/> |

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



DENTAL CHARTING