



# DENTISTREE DENTAL CLINIC

File No:

5342

|                                  |                                                                 |                                           |                                                               |
|----------------------------------|-----------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------|
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| Date of Birth: 16.2.1990         | Sex: <input type="radio"/> M <input checked="" type="radio"/> F | Nationality:                              |                                                               |
| How do you know about us?        | <input type="radio"/> Family or Friends                         | <input checked="" 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: \_\_\_\_\_

| 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="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 _____ |                                       |                                           |

| 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"/> | <input checked="" type="checkbox"/> | Nickel, Arsenic        |
| 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



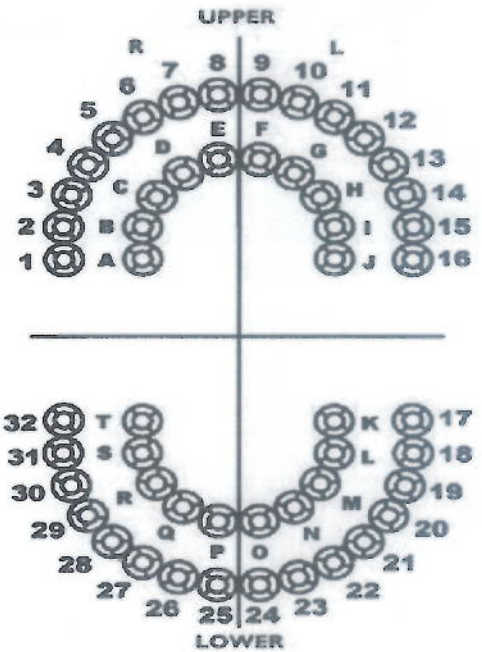
To the best of my knowledge, all of the preceding answer and information provided are true and correct.  
If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

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

| 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"/> |

| 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"/> |

## 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      | <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** →

