



# DENTISTREE DENTAL CLINIC

File No:

5383

|                                                                                                                                                                           |                                                      |              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------|--|
| Name: <u>Marham Wahidi</u>                                                                                                                                                |                                                      |              |  |
| Mobile no.: <u>0509444113</u>                                                                                                                                             |                                                      | Email:       |  |
| Date of Birth: <u>2015</u>                                                                                                                                                | Sex: <input type="radio"/> M <input type="radio"/> F | Nationality: |  |
| 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

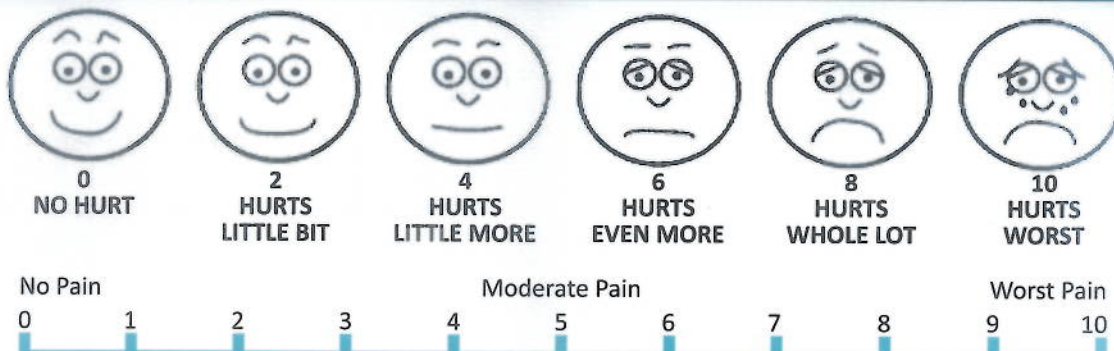
Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

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

| 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                        |                                                    |                                       |                                           |
| <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)                                            |                                                    |                                       |                                           |
| 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.

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

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

UPPER

LOWER

| 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"/> |
| <b>Total Points</b>                                        | <b>14</b> | <input type="checkbox"/> | <input type="checkbox"/> |

#### YOUR FALL RISK →

0 1 2 3 4 5 6 7 8+

LOW MODERATE AT RISK HIGH URGENT SEVERE