



# DENTISTREE DENTAL CLINIC

File No:

5412

|                                                                                                                                                                           |  |                                                                 |                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|------------------------------|
| Name: <u>Taoufik Dalhaoui</u>                                                                                                                                             |  |                                                                 |                              |
| Mobile no.: <u>056 4077809</u>                                                                                                                                            |  | Email: <u>Taoufik.Dalhaoui@gmail.com</u>                        |                              |
| Date of Birth: <u>25/03/1993</u>                                                                                                                                          |  | Sex: <input checked="" type="radio"/> M <input type="radio"/> F | Nationality: <u>Moroccan</u> |
| 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"/> |                                     | <u>Vape</u>            |

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"/> |                                     | <u>penicillin</u>      |
| 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"/> |                        |

| 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

|              |                          |                           |                         |                         |                      |
|--------------|--------------------------|---------------------------|-------------------------|-------------------------|----------------------|
|              |                          |                           |                         |                         |                      |
| 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 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Moderate 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                | 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 type="checkbox"/> | <input checked="" type="checkbox"/> |
| Do you want complete dental care?            | <input type="checkbox"/> | <input checked="" 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

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 stumble 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** →