



DENTISTREE DENTAL CLINIC

File No:

5715

| | | | |
|---|--|---|---------------------|
| Name: Ulan Beisenbayeva | | | |
| Mobile no.: 0985390289 | | Email: ubeisenbayeva@gmail.com | |
| Date of Birth: 15.10.1998 | | Sex: <input type="radio"/> M <input checked="" type="radio"/> F | Nationality: Kazakh |
| 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: | | | |
| Local anesthetics (Novocaine) | Yes | No | Others, Please Specify |
| 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"/> | |
| Additional questions for women. | | | |
| Are you pregnant or trying to get pregnant? | Yes | No | Others, Please Specify |
| | | <input checked="" type="checkbox"/> | |
| if yes, expected delivery date: _____ | | | |
| Are you taking oral contraceptives? | | <input checked="" type="checkbox"/> | |

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY

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

Signature of Patient, Parent or Guardian

Date

08.11.2025

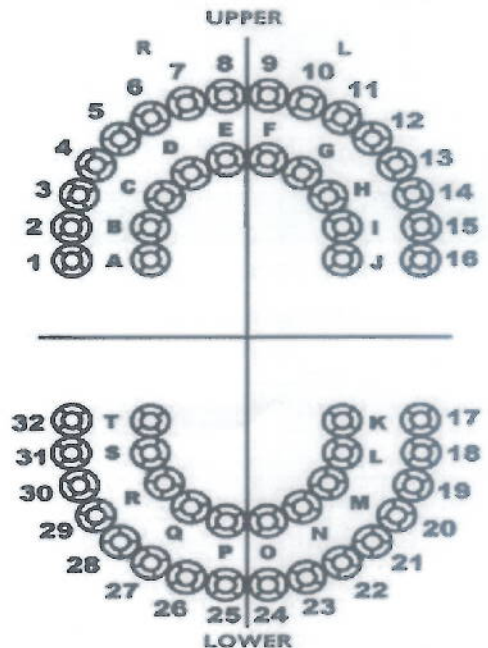
PATIENT ASSESSMENT FORM

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

YOUR FALL RISK →

