



Name: <u>Sune Coetzer</u>			
Mobile no.: <u>055 44 737 89</u>	Email: <u>Sunecoetzer@gmail.com</u>		
Date of Birth: <u>30/05/2000</u>	Sex: ☐ M ☒ F	Nationality:	
How do you know about us?	☐ Family or Friends	☒ Internet	☐ Newspapers ☐ 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

- | | | | |
|---|--|---------------------------------------|---|
| ☐ High Blood Pressure | ☐ Low Blood Pressure | ☐ Rheumatic Fever | ☐ Fainting / Seizures |
| ☐ Asthma | ☐ Heart Attack | ☐ Epilepsy | ☐ Leukemia |
| ☐ Heart Disease | ☐ Kidney Disease | ☐ Liver Disease | ☐ Lung Disease |
| ☐ Thyroid Problem | ☐ Diabetes | ☐ Tuberculosis | ☐ Hepatitis/Jaundice |
| ☐ Stroke | ☐ Arthritis | ☐ Cancer | ☐ AIDS/HIV Infection |
| ☐ Creutzfeldt-Jakob disease (CJD) | ☐ Others, Please Specify _____ | | |

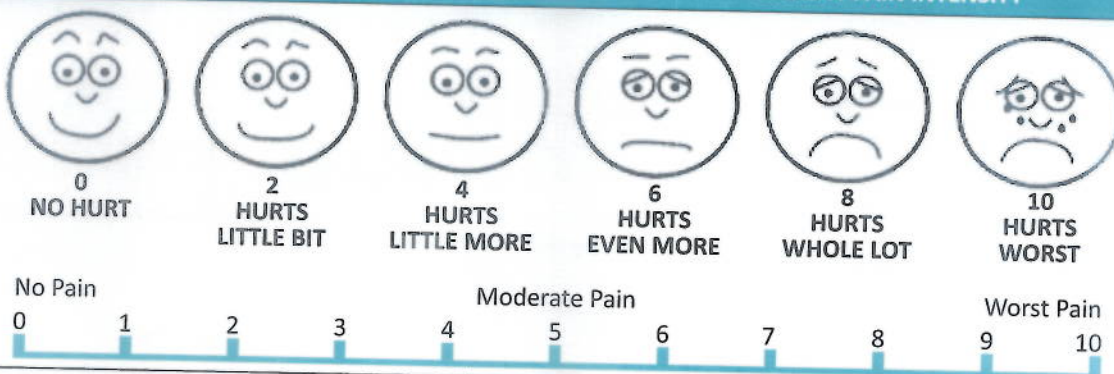
Are you allergic, or have you reacted adversely to any of the following:

	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.

Signature of Patient, Parent or Guardian

Date

15/12/25

PATIENT ASSESSMENT FORM

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

Oral Health Information Pediatric/Child	
Does your child use a toothpaste with fluoride in it?	☐ Yes ☐ No
Do you help your child with toothbrushing?	☐ Yes ☐ No
Have your child experience in a dental treatment?	☐ Yes ☐ No
Have your child ever had cavities?	☐ Yes ☐ No
Does your child complain of mouth pain?	☐ Yes ☐ No
Does your child take a bottle to bed?	☐ Yes ☐ No
Does your child loves to eat foods like Chocolates, candy, snacks a lot?	☐ Yes ☐ No
Does your child gums bleed easily?	☐ Yes ☐ No

Health Information for TMJ	
Do you clench or grind your jaws frequently?	☐ Yes ☐ No
Do your jaws ever feel tired?	☐ Yes ☐ No
Does your jaw get stuck so that you can't open freely?	☐ Yes ☐ No
Does it hurt when you chew or open wide to take a bite?	☐ Yes ☐ No
Do you have earaches or pain in front of the ears?	☐ Yes ☐ No
Do you have any jaw headaches upon awaking in the morning?	☐ Yes ☐ No
Do you find jaw pain or discomfort extremely frustrating /depressing?	☐ Yes ☐ No
Do you have a temporomandibular (jaw) disorder (TMD)?	☐ Yes ☐ No
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐ Yes ☐ No
Are you unable to open your mouth as far as you want?	☐ Yes ☐ No
Are you aware of an uncomfortable bite?	☐ Yes ☐ No
Have you had a blow to the jaw (trauma)?	☐ Yes ☐ No
Are you a habitual gum chewer or pipe smoker?	☐ Yes ☐ No

DENTAL CHARTING	

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	

FALL RISK ASSESSMENT	
Falls are common for 65yrs of age and older.	Points
Do you fallen in the pass years?	2
Are you using or advice to use cane or walker?	2
Are you lose a balance while walking?	1
You Worry about falling?	1
Do you use your arm/s to push your self from a chair?	1
Do you have trouble stepping up onto a curb/steps?	1
Are you sways when standing stationary?	1
Do you take short narrow step?	1
Are you stumble often or look at the ground when you walk?	1
Do you frequently have to rush to the toilet?	1
Do you have lost some feeling in one or both of your feet?	1
Do you take any medication to feel light headed or sleepy?	1
Total Points	14

LOW

MODERATE

AT RISK

HIGH

URGENT

SEVERE

012345678+

YOUR FALL RISK

Dr. Pratik Premjani
Specialist Orthodontics
DHA-00030423003
DUBAIFREE DENTAL CLINIC
Shop 3, Wasi Port Views 8,
Next to Hyatt Place,
Al Mina Road, Jumeirah 1, Dubai
United Arab Emirates

DENTIST'S Stamp :
Date : 15/12/25