



DENTISTREE DENTAL CLINIC

File No:

2768

Name: Julius L. Segundo

Mobile no.: 0528977665

Email:

Nationality: Filipino

Date of Birth: July 20 1993

Sex: M F

Newspapers Others

How do you know about us? Family or Friends Internet

MEDICAL HISTORY

Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

Chief Complaint:

Yes No

Others, Please Specify

All details will be strictly confidential.

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

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

Yes No

Others, Please Specify

Additional questions for women.

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 NO HURT



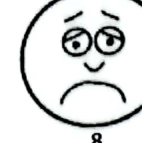
2 HURTS LITTLE BIT



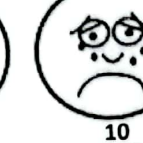
4 HURTS LITTLE MORE



6 HURTS EVEN MORE



8 HURTS WHOLE LOT



10 HURTS WORST

No Pain

Moderate Pain

Worst 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.

Signature of Patient, Parent or Guardian

Date

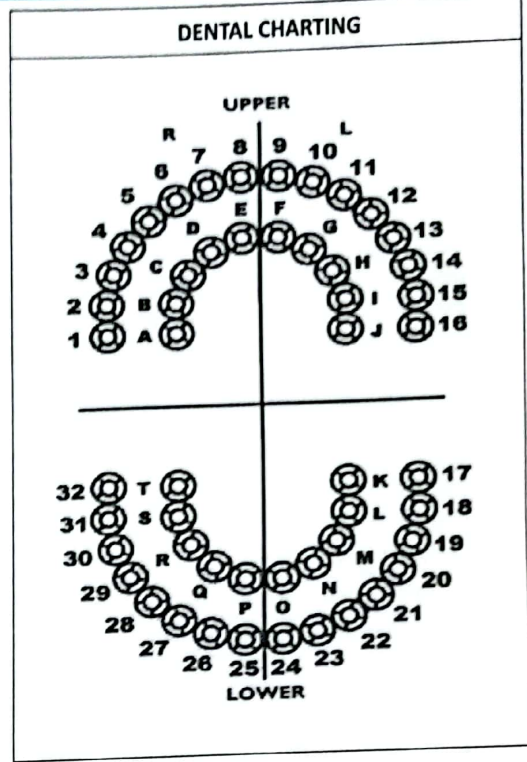
23/10/21

PATIENT ASSESSMENT FORM

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"/>




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 5 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"/>
Total Points	14	<input type="checkbox"/>	<input type="checkbox"/>

YOUR FALL RISK →




Dr. Pratik Premjani
 Specialist Orthodontics
 DHA-00058483-003
DENTISTREE DENTAL CLINIC

Dentist Stamp :

Date :

20/10/21

Shop 3, Wasl Port Views 8,
 Next to Hyatt Place,
 Al Mina Road, Jumeirah 1, Dubai
 United Arab Emirates