PATIENT ASSESSMENT FORM

Oral Health Information Adult	Yes No
Do you gag easily?	1010
Do you wear dentures?	
Does food catch between your teeth?	
Do you have difficulty in chewing your food?	
Do you chew on only one side of your mouth?	
Do your gums bleed easily?	
Do your gums bleed when you floss?	
Do your gums feel swalen or tender?	
Are your teeth sensitive?	1016
Do you take fluoride supplements?	
Do you prefer to save your teeth?	0/0
Do you want complete dental care?	0/0

Oral Health Information Pediatric/Child		Yes	No	
Does your child use a th	oothpase with flouride in it?			
Do you help your child	Do you help your child with toothbrushing?			
Have your child experin	e in a dental treatment?			
Have your child ever ha	e your child ever had cavities?			
Does your child complain of mouth pain?				
Does your child take a b	Does your child take a bottle to bed?			
Does your Child loves to	Does your Child loves to eat foods like Chocolates, candy, snacks a lot?			
Does your child gums b	eed easily?			

Health Information fo	Yes	No		
Do you clench or grind				
Do your jaws ever feel t	our jaws ever feel tired?			
Does your jaw get stuck	so that you can't open freely?			
Does it hurt when you o	new or open wide to take a bite?			
Do you have earaches o	pain in front of the ears?			
Do you have any jaw he	daches upon awaking in the morning?			
Do you find jaw pain or	liscomfort extremely frustrating /depressing?			
Do you have a temporo	nandibular (jaw) disorder (TMD)?			
Do you have pain in the	n the face, cheeks, jaws, joints, throat, or temples?			
Are you unable to open	nable to open your mouth as far as you want?			
Are you aware of an und	omfortable bite?			
lave you had a blow to the jaw (trauma)?				
Are you a habitual gum thewer or pipe smoker?				

DENTAL	CHARTING
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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	

Do you fallen in the pass years? Are you using or advice to use cane or walker? Are you lose a balance while walking? You Worry about falling? Do you use your arm/s to push your self from a chair? Do you have trouble steeping up onto a crub/steps? Are you sways when standing stationary? Do you take short narrow step? Are you stamble often o look at the ground when you walk? Do you frequently have to rush to the toilet? Do you have lost some feeling in one or both of your feet? Do you take any medication to feel light headed or sleepy? Total Points YOUR FALL RISK O 1 2 3 4 5 6 7 8+ LOW MODERATE AT RISK HIGH URGENT SEVERE DOP. Pratik Premjani Total Points		older.	Points	Yes	No	
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