

Name: DR SANJAY BATHUA	Email: sanjay_bathua@yahoo.com	
Mobile no.: 052 6822555	Sex: <input checked="" type="radio"/> M <input type="radio"/> F	Nationality: INDIA
Date of Birth: 25/10/1971	<input type="radio"/> Family or Friends	<input type="radio"/> Internet <input type="radio"/> Newspapers <input type="radio"/> Others
How do you know about us?		

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

<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 NA			

Are you allergic, or have you reacted adversely to any of the following: Yes No Others, Please Specify

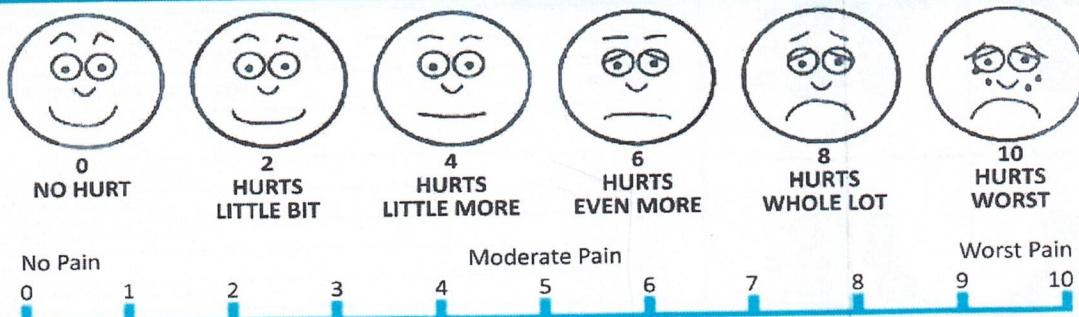
Local anesthetics (Novocaine)	Yes	No	Others, Please Specify
Penicillin or other antibiotics			
Asperin or Ibuprofen			
Reactions to metals			
Latex or rubber dam			
Foods			

Additional questions for women. Yes No Others, Please Specify

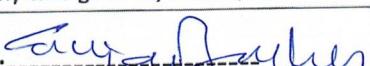
Are you pregnant or trying to get pregnant?	Yes	No	Others, Please Specify
if yes, expected delivery date: _____			

Are you taking oral contraceptives? Yes No Others, Please Specify

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY



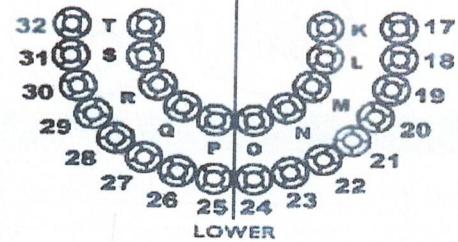
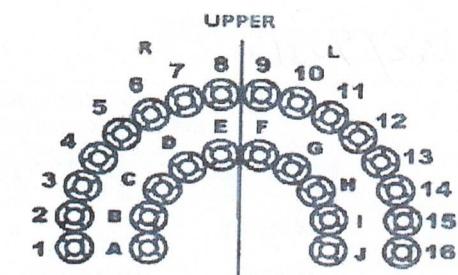
To the best of my knowledge, all of the preceding answer and information provided are true and correct.
 If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature: 

Date: 15/Febr/25

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"/>

DENTAL CHARTING

Oral Health Information Pediatric/Child

	Yes	No
Does your child use a toothpaste with fluoride in it?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you help your child with toothbrushing?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have your child experience in a dental treatment?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have your child ever had cavities?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does your child complain of mouth pain?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does your child take a bottle to bed?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does your child loves to eat foods like Chocolates, candy, snacks a lot?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does your child gums bleed easily?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Health Information for TMJ

	Yes	No
Do you clench or grind your jaws frequently?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do your jaws ever feel tired?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does your jaw get stuck so that you can't open freely?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does it hurt when you chew or open wide to take a bite?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you have earaches or pain in front of the ears?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you have any jaw headaches upon awaking in the morning?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you find jaw pain or discomfort extremely frustrating /depressing?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you have a temporomandibular (jaw) disorder (TMD)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are you unable to open your mouth as far as you want?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are you aware of an uncomfortable bite?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had a blow to the jaw (trauma)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are you a habitual gum chewer or pipe smoker?	<input type="checkbox"/>	<input checked="" 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 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 checked="" type="checkbox"/>
Are you using or advice to use cane or walker?	2	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are you lose a balance while walking?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
You Worry about falling?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you use your arm/s to push your self from a chair?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you have trouble stepping up onto a curb/steps?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are you sways when standing stationary?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you take short narrow step?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are you stumble often or look at the ground when you walk?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you frequently have to rush to the toilet?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you have lost some feeling in one or both of your feet?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you take any medication to feel light headed or sleepy?	1	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	14	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Total Points			

**YOUR
FALL RISK →**
