



485

Name: HELEN BOW CESARIO DA SILVA				
Mobile no.: 54 520 9172		Email: HELENBOW@gmail.com		
Date of Birth: 25/02/76		Sex: ☐ M ☒ F		Nationality: Brazil
How do you know about us?		☒ Family or Friends ☐ Internet ☐ Newspapers ☐ Others		

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?	✓		Blood Pressure, Sugar
Have you ever been hospitalized or had a major operation?	✓		Bariatric / C-Section
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.

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.

Oral Health Information Adult

Do you gag easily?	☐	☒
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 swollen or tender?	☐	☒
Are your teeth sensitive?	☒	☐
Do you take fluoride supplements?	☐	☒
Do you prefer to save your teeth?	☒	☐
Do you want complete dental care?	☒	☐

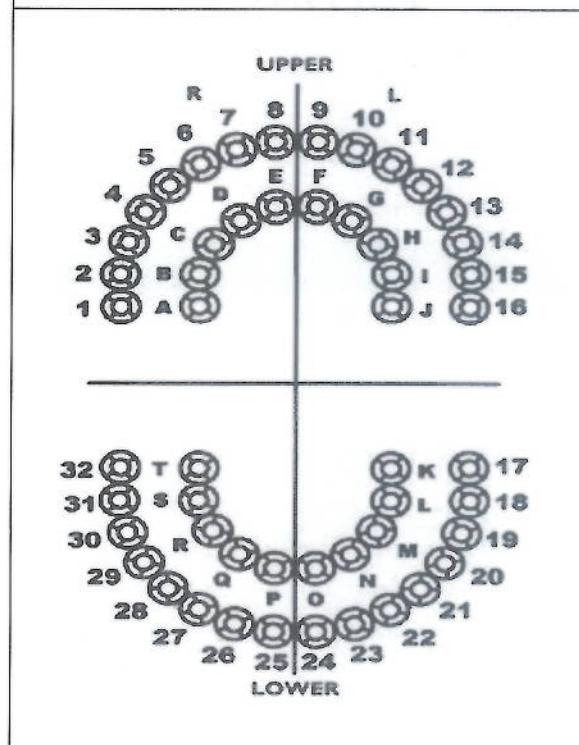
Oral Health Information Pediatric/Child

Yes	No
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐

Health Information for TMJ

Yes	No
☐	☒
☐	☒
☐	☒
☐	☒
☐	☒
☐	☒
☐	☒
☐	☒
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☐	☒
☐	☒
☐	☒

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	☐	☒
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 crub/steps?	1	☐	☒
Are you sways when standing stationary?	1	☐	☒
Do you take short narrow step?	1	☐	☒
Are you stamble 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	☐	☒
	14	☐	☐
Total Points			

YOUR FALL RISK →

