



DENTISTREE DENTAL CLINIC

File No:

4851

Name: AMAR TANILANI

Mobile no.: 055 300 3766

Email: AMARTANILANI@GMAIL.COM

Date of Birth: 21/12/1977

Sex: ☒ M ☐ F

Nationality: INDIAN

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?

☒☐

HYPERTENSION

Have you ever been hospitalized or had a major operation?

☐☒

Have you ever had any complications following dental treatment?

☐☒

Are you a smoker?

☒☐

SOCRALLY

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.

N/A

Yes

No

Others, Please Specify

Are you pregnant or trying to get pregnant?

☐☒

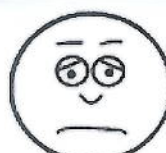
if yes, expected delivery date:

N/A

Are you taking oral contraceptives?

N/A

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY

0
NO HURT2
HURTS
LITTLE BIT4
HURTS
LITTLE MORE6
HURTS
EVEN MORE8
HURTS
WHOLE LOT10
HURTS
WORST

No Pain

Moderate Pain

Worst Pain

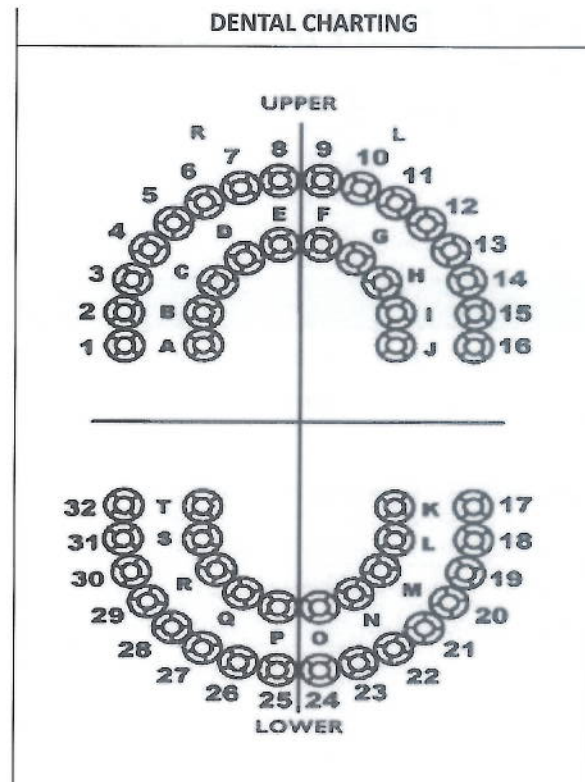
0 1 2 3 4 5 6 7 8 9 10

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		Yes	No
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
Does your child use a thoothpase with flouride in it?		☐	☐
Do you help your child with toothbrushing?		☐	☐
Have your child experince in a dental treatment?		☐	☐
Have your child ever had cavities?		☐	☐
Does your child complain of mouth pain?		☐	☐
Does your child take a bottle to bed?		☐	☐
Does your Child loves to eat foods like Chocolates, candy, snacks a lot?		☐	☐
Does your child gums bleed easily?		☐	☐

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



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 →

