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Name: RIDHIMA				
Mobile no.: 0505322518	Email: RIDHIMA@KUNDAN GROUP.COM			
Date of Birth: 30/10/87	Sex: <input type="radio"/> M <input checked="" type="radio"/> F	Nationality: INDIAN		
How do you know about us?	<input checked="" type="radio"/> Family or Friends <input type="radio"/> Internet <input type="radio"/> Newspapers <input type="radio"/> 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?	<input checked="" type="checkbox"/>		
Are you taking any medications, pills, or drugs?	<input checked="" type="checkbox"/>		Supplements
Have you ever been hospitalized or had a major operation?	<input checked="" type="checkbox"/>		Deliveries
Have you ever had any complications following dental treatment?	<input checked="" type="checkbox"/>		
Are you a smoker?	<input checked="" type="checkbox"/>		

**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 INSULIN RESISTANCE

**Are you allergic, or have you reacted adversely to any of the following:**

Are you allergic, or have you reacted adversely, to any of the following:	Yes	No
Local anesthetics (Novocaine)	<input checked="" type="checkbox"/>	
Penicillin or other antibiotics	<input checked="" type="checkbox"/>	
Asperin or Ibuprofen	<input checked="" type="checkbox"/>	
Reactions to metals	<input checked="" type="checkbox"/>	
Latex or rubber dam	<input checked="" type="checkbox"/>	
Foods	<input checked="" type="checkbox"/>	coconut water
<b>Additional questions for women.</b>	Yes	No
Are you pregnant or trying to get pregnant?	<input checked="" type="checkbox"/>	
if yes, expected delivery date: _____		
Are you taking oral contraceptives?		<input checked="" type="checkbox"/>

**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 of Patient, Parent or Guardian**

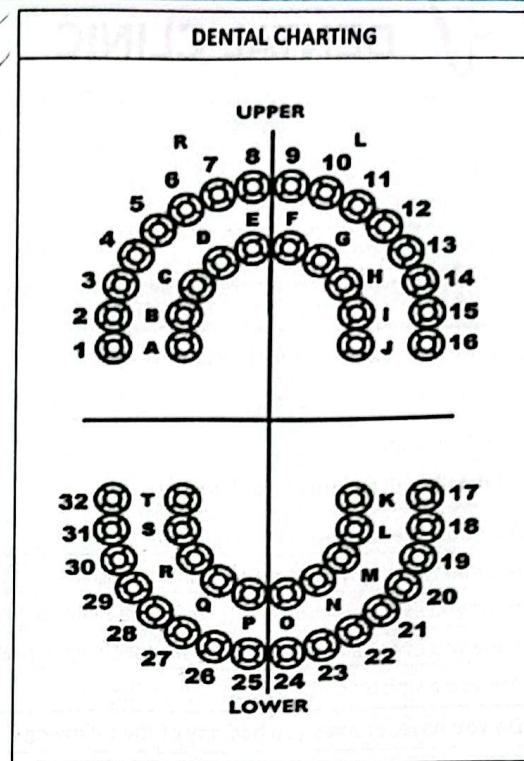
7/ May 2025

# 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 type="checkbox"/>	<input checked="" 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 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						
Do you fallen in the pass years?	2	<input type="checkbox"/>						
Are you using or advice to use cane or walker?	2	<input type="checkbox"/>						
Are you lose a balance while walking?	1	<input type="checkbox"/>						
You Worry about falling?	1	<input type="checkbox"/>						
Do you use your arm/s to push your self from a chair?	1	<input type="checkbox"/>						
Do you have trouble stepping up onto a curb/steps?	1	<input type="checkbox"/>						
Are you sways when standing stationary?	1	<input type="checkbox"/>						
Do you take short narrow step?	1	<input type="checkbox"/>						
Are you stumble often or look at the ground when you walk?	1	<input type="checkbox"/>						
Do you frequently have to rush to the toilet?	1	<input type="checkbox"/>						
Do you have lost some feeling in one or both of your feet?	1	<input type="checkbox"/>						
Do you take any medication to feel light headed or sleepy?	1	<input type="checkbox"/>						
	14	<input type="checkbox"/>						
Total Points								
0	1	2	3	4	5	6	7	8+
LOW	MODERATE	AT RISK	HIGH	URGENT	SEVERE			

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

Dentist Stamp : *Dr. Arshik*

Date : \_\_\_\_\_