



DENTISTREE DENTAL CLINIC

File No:

5274

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Date of Birth:	7-Nov-1965	Sex:	☒ M ☐ F
		Nationality:	Indian
How do you know about us? ☐ Family or Friends ☒ Internet ☐ Newspapers ☐ Others			

MEDICAL HISTORY

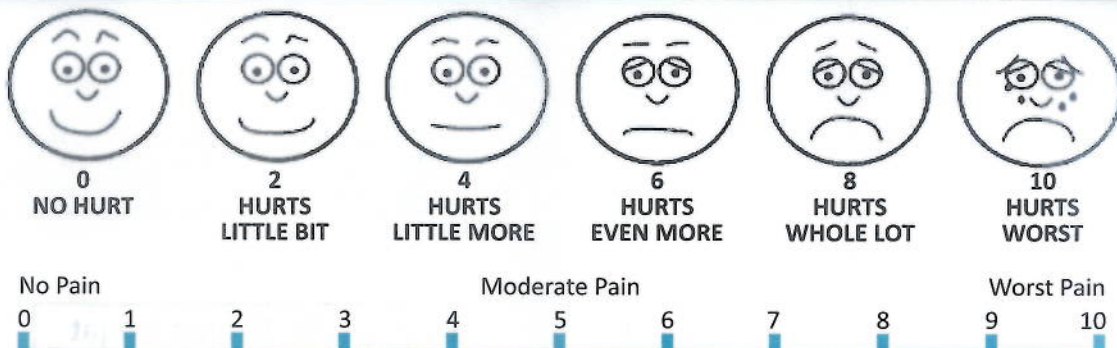
Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

Chief Complaint: _____

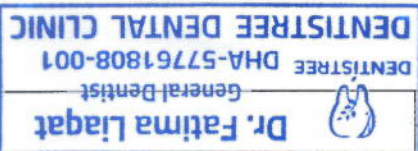
All details will be strictly confidential.	Yes	No	Others, Please Specify
Are you under a physician's care now?	☒	☐	
Are you taking any medications, pills, or drugs?	☒	☐	
Have you ever been hospitalized or had a major operation?	☒	☐	
Have you ever had any complications following dental treatment?	☒	☐	
Are you a smoker?	☐	☐	
Do you have, or have you had any of the following			
☐ 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	☐	☐	
Aspirin 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?	☐	☒	NA
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.

Date : 07/05/25
Dentist Stamp :



Falls are common for 65yrs of age and older.		Points	Yes	No
Do you fall in the past 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 curb/steps?	1	☐	☐	☐
Are you sways when standing stationary?	1	☐	☐	☐
Do you take short narrow step?	1	☐	☐	☐
Are you stumble 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	☐	☐	☐
Total Points		14	☐	☐

FALL RISK ASSESSMENT

YOUR FALL RISK



Category	Lips	Tongue	Gums & Tissues	Saliva	Natural Teeth	Denture(s)
0 = healthy	Smooth, Pink, Moist	Normal, Pink, Moist	Pink, Moist, Smooth	Moist Tissues, Watery	No Decayed/ Broken Teeth	No Broken Areas
1 = changes	Dry, chapped, red at corners, Swelling or lump	Patchy, fissured, red, coated, ulcerated, swollen	Dry, shiny, rough, Swollen, bleeding	Dry, sticky tissues, Little saliva present	1 to 3 decayed/ 1 broken teeth	1 Broken Area
2 = unhealthy	Swelling or lump	Patch that is red & ulcerated, swollen	Generalized redness	No saliva present	4 or more decayed & broken teeth	More than 1 broken
Score						

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?	☐	☐	☐

Oral Health Information Pediatric/Child		Yes	No
Does your child use a toothpaste with fluoride in it?	☐	☐	☐
Do you help your child with toothbrushing?	☐	☐	☐
Have your child experience 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?	☐	☐	☐

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?	☐	☒	☐

