



Name: VALLERIE ANNE SADIAGA

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Date of Birth: JULY 01, 1985

Sex: ☐ M ☒ F

Nationality: FILIPINO

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: BRIDGE COMPLICATION

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

☒

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?

☒

if yes, expected delivery date:

Are you taking oral contraceptives?

☒

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY



0
NO HURT



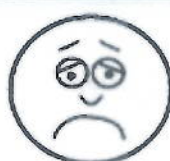
2
HURTS
LITTLE BIT



4
HURTS
LITTLE MORE



6
HURTS
EVEN MORE



8
HURTS
WHOLE LOT



10
HURTS
WORST

No Pain

0

1

2

3

4

5

6

7

8

9

10

Moderate Pain

Worst Pain

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

Date

NOV. 28, 2025

PATIENT ASSESSMENT FORM

Oral Health Information Adult	
Do you gag easily?	☐ Yes ☒ No
Do you wear dentures?	☐ Yes ☒ No
Does food catch between your teeth?	☐ Yes ☒ No
Do you have difficulty in chewing your food?	☐ Yes ☒ No
Do you chew on only one side of your mouth?	☐ Yes ☒ No
Do your gums bleed easily?	☐ Yes ☒ No
Do your gums bleed when you floss?	☐ Yes ☒ No
Do your gums feel swollen or tender?	☐ Yes ☒ No
Are your teeth sensitive?	☐ Yes ☒ No
Do you take fluoride supplements?	☐ Yes ☒ No
Do you prefer to save your teeth?	☐ Yes ☒ No
Do you want complete dental care?	☐ Yes ☒ No

Oral Health Information Pediatric/Child	
Does your child use a toothpaste with fluoride in it?	☐ Yes ☒ No
Do you help your child with toothbrushing?	☐ Yes ☒ No
Have your child experience in a dental treatment?	☐ Yes ☒ No
Have your child ever had cavities?	☐ Yes ☒ No
Does your child complain of mouth pain?	☐ Yes ☒ No
Does your child take a bottle to bed?	☐ Yes ☒ No
Does your Child loves to eat foods like Chocolates, candy, snacks a lot?	☐ Yes ☒ No
Does your child gums bleed easily?	☐ Yes ☒ No

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

DENTAL CHARTING	

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, ulcerated or lump	Patchy, fissured, red, coated	Dry, shiny, rough, swollen 1 to 6 teeth	Dry, sticky tissues, Little saliva present	1 to 3 decayed/ 1 broken teeth	1 Broken Area
2 = unhealthy	Swelling or lump	ulcerated, swollen	Swollen, bleeding, generalized redness	No saliva present	4 or more decayed & broken teeth	More than 1 broken
Score						

FALL RISK ASSESSMENT	
Falls are common for 65yrs of age and older.	
Points	Yes No
2	☐ Yes ☐ No
2	☐ Yes ☐ No
Are you using or advice to use cane or walker?	☐ Yes ☐ No
Are you lose a balance while walking?	☐ Yes ☐ No
You Worry about falling?	☐ Yes ☐ No
Do you use your arm/s to push your self from a chair?	☐ Yes ☐ No
Do you have trouble stepping up onto a curb/steps?	☐ Yes ☐ No
Are you sways when standing stationary?	☐ Yes ☐ No
Do you take short narrow step?	☐ Yes ☐ No
Are you stumble often or look at the ground when you walk?	☐ Yes ☐ No
Do you frequently have to rush to the toilet?	☐ Yes ☐ No
Do you have lost some feeling in one or both of your feet?	☐ Yes ☐ No
Do you take any medication to feel light headed or sleepy?	☐ Yes ☐ No
14	☐ Yes ☐ No
Total Points	

YOUR FALL RISK ←

LOW MODERATE AT RISK HIGH URGENT SEVERE

0 1 2 3 4 5 6 7 8+

Dr. Hengameh Shadatzah
General Dentist
DENTISTREE DENTAL CLINIC
DHA-77225976-004

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

Dentist Stamp :
Date : 28/11/25