

DENTAL HISTORY

PLEASE DESCRIBE "YES" ANSWERS

1. What is the main reason for this visit? _____
2. Are you having any specific dental problems? Yes No _____
3. Date of your last dental exam: ____/____/____ cleaning: ____/____/____ _____
4. How often do you brush? _____ floss? _____ _____
5. Have you been shown the proper way to brush and floss? Yes No _____
6. Do your gums bleed? When? Yes No _____
7. Does food catch between your teeth? Where? Yes No _____
8. Are your teeth sensitive to: Hot Cold Sweets Chewing Yes No _____
9. Do you experience an unpleasant odor or taste in your mouth? Yes No _____
10. Have you ever been told that you have periodontal (gum) disease? Yes No _____
11. Have you ever been referred for or undergone periodontal (gum) surgery? Yes No _____
12. Are you satisfied with the health of your mouth? Yes No _____
13. Do you have any removable appliance(s) in your mouth? Yes No _____
 Full Denture Partial Denture Night Guard Occlusal Splint
 Retainer Other _____
14. Do you wish to save your remaining teeth? Yes No _____
15. Do you feel nervous about having any dental treatment? Yes No _____
16. How may we help you? _____

_____/_____/_____ DR./STAFF _____ PATIENT _____
DATE SIGNATURE SIGNATURE

MEDICAL UPDATES: Please list any changes in medications, health status, or hospitalization:

| DATE | CHANGES | PATIENT'S SIGNATURE | B.P. | DR./STAFF |
|----------------|-------------------------------|---------------------|-----------|-----------|
| ____/____/____ | None <input type="checkbox"/> | _____ | ____/____ | _____ |
| ____/____/____ | None <input type="checkbox"/> | _____ | ____/____ | _____ |
| ____/____/____ | None <input type="checkbox"/> | _____ | ____/____ | _____ |
| ____/____/____ | None <input type="checkbox"/> | _____ | ____/____ | _____ |
| ____/____/____ | None <input type="checkbox"/> | _____ | ____/____ | _____ |