

DENTAL HISTORY

1. Do you have a specific dental problem? Describe _____ Yes No

2. Do you have dental examinations on a routine basis? Last visit _____ Yes No
How often do you have your teeth cleaned? _____ x-rayed? _____
3. Would you describe your present dental health as good? Comments _____ Yes No

4. Do you think you have active decay or gum disease? _____ Yes No
5. Do your gums ever bleed? Discuss _____ Yes No
6. Have you ever been treated for any gum diseases (gingivitis, periodontitis, trenchmouth, pyorrhea)? _____ Yes No
7. How often do you brush? _____ Floss? _____ Use mouthrinses? _____
8. Do you feel nervous about having dental treatment? _____ Yes No
9. Have you ever had a bad experience in a dental office? Describe _____ Yes No

10. Do you want to keep your remaining teeth? _____ Yes No
11. Do you like your smile? Why? _____ Yes No
12. Are your teeth sensitive to hot\cold? _____ Sweets? _____ Chewing? _____ Yes No
13. Do you ever brux or grind your teeth? Discuss _____ Yes No
14. Have you ever had orthodontic treatment (tooth straightening)? _____ Yes No
15. Do you ever have clicking, popping or discomfort in the jaw joints (TMJ)? _____ Yes No
Discuss _____
16. Have you had root canal treatment? _____ Yes No
17. Do you have dental implants? _____ Yes No
18. Do you have removable dental appliances? _____ Yes No
19. Do you use tobacco? What type? _____ Yes No
20. Do you frequently snack on sweets, chew gum, or drink pop? _____ Yes No
21. Does food generally wedge between certain teeth? _____ Yes No
22. What has been used for comfort in previous dental treatment?
 Local anesthetic N₂O gas Neither
23. Have you had a reaction to dental anesthetic? _____ Yes No
24. Have you been told you need to be pre-medicated for dental treatment? _____ Yes No
25. Do you have any other comments or concerns that you would like to bring to our attention? Yes No

X _____ Date _____
Patient Signature (Parent or Guardian)

Reviewed by: Doctor _____ Date _____ B.P. _____