DENTAL HISTORY

Why have you come to the dentist today? _____

_____

_____

Your comfort level in a dentist office is 1 (least comfortable) 2 3 4 5 (most comfortable)

Have you experienced problems associated with any previous dental work? ❑ Yes ❑ No

Do you have frequent headaches? ❑ Yes ❑ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

How many times a day do you brush? _____ Do you floss? _____

Type of bristle on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

Do you use anything in addition to your brush and floss? ❑ Yes ❑ No

If yes, what? _____

Do your gums ever bleed? ❑ Yes ❑ No

Have you ever had gum/periodontal disease? ❑ Yes ❑ No

Have you ever had root planing or a deep cleaning? ❑ Yes ❑ No

Are any of your teeth loose? ❑ Yes ❑ No

Does food get caught between your teeth? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, sweets or pressure?

_____

Do you still have your wisdom teeth? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

If yes, why? _____

Do you need to be premedicated with antibiotic before dental work? ❑ Yes ❑ No

Have you ever had orthodontic treatment? ❑ Yes ❑ No

When was the last time you visited a dentist? _____yrs. _____mos.

For Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

_____

_____

Medical History Update:

1. Date: _____ Comments: _____

2. Date: _____ Comments: _____

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