

# DENTAL HISTORY

Why have you come to the dentist today? \_\_\_\_\_

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

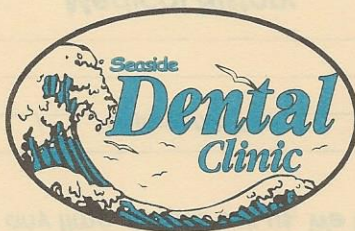
I verbally reviewed the medical/dental information above with the patient named herein. Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_

## Medical History Update:

1. Date: \_\_\_\_\_ Comments: \_\_\_\_\_

2. Date: \_\_\_\_\_ Comments: \_\_\_\_\_



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