

# ADULT DENTAL HISTORY



Patient's Name

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Birthdate: \_\_\_\_\_

- |  |                          |   |                          |
|--|--------------------------|---|--------------------------|
| Have you had long periods of bad breath?                                   | <input type="checkbox"/> | Do you have problems with your teeth or fillings breaking?                          | <input type="checkbox"/> |
| Have you had long periods of a bad taste in your mouth?                    | <input type="checkbox"/> | Do you have any large or old amalgam (silver) fillings?                             | <input type="checkbox"/> |
| Have you had prolonged periods of pain in your gums?                       | <input type="checkbox"/> | Do you chew on just one side of your mouth?   | <input type="checkbox"/> |
| Do your gums ever feel tender or irritated after brushing?                 | <input type="checkbox"/> | Do you experience frequent neckaches, sore jaw muscles or headaches?                | <input type="checkbox"/> |
| Do you ever avoid brushing because it causes discomfort?                   | <input type="checkbox"/> | Does your jaw hurt when you open wide?  | <input type="checkbox"/> |
| Do you ever avoid flossing because it causes discomfort?                   | <input type="checkbox"/> | Does your jaw ever lock or catch?   | <input type="checkbox"/> |
| Have you been diagnosed with periodontal disease (pyorrhea)?               | <input type="checkbox"/> | Does your jaw ever make a popping, clicking or grating sound?                       | <input type="checkbox"/> |
| Have you ever had periodontal treatment (root planing, gum surgery, etc.)? | <input type="checkbox"/> | Do you clench or grate your teeth when you are awake?                               | <input type="checkbox"/> |
|  |                          | Do you clench or grate your teeth when you are asleep?                              | <input type="checkbox"/> |
| Have you ever had endodontal treatment (root canals)?                      | <input type="checkbox"/> | Have you ever had orthodontic treatment (braces, etc.)?                             | <input type="checkbox"/> |
| Do you have missing teeth that have not been replaced?                     | <input type="checkbox"/> | Have other members of your family had problems with their teeth?                    | <input type="checkbox"/> |
| Are any of your teeth sensitive to heat?                                   | <input type="checkbox"/> | Are you unhappy with the shape of any of your teeth?                                | <input type="checkbox"/> |
| Are any of your teeth sensitive to cold?                                   | <input type="checkbox"/> | Are you unhappy with the color of any of your teeth?                                | <input type="checkbox"/> |
| Are any of your teeth sensitive to sweets?                                 | <input type="checkbox"/> | Are you unhappy with the alignment of your teeth?                                   | <input type="checkbox"/> |
| Are any of your teeth sensitive to pressure?                               | <input type="checkbox"/> | Do you ever avoid laughing or smiling because of your teeth?                        | <input type="checkbox"/> |
| Do your teeth hurt when you chew?  | <input type="checkbox"/> |   |                          |
|  |                          |   |                          |
| Do you have a complete denture (full upper, full lower or both)?           | <input type="checkbox"/> | If "Yes" which ones and when?   | <input type="checkbox"/> |
| If "Yes" are they stable, comfortable and functional?                      | <input type="checkbox"/> | Have you experienced any problems with your wisdom teeth?                           | <input type="checkbox"/> |
| When were they made? _____   |                          | If "Yes," please explain: _____   |                          |
| Do you have a partial denture?   | <input type="checkbox"/> | _____   |                          |
| If "Yes" is it stable, comfortable and functional?                         | <input type="checkbox"/> | _____   |                          |
| When was it made? _____  |                          |   |                          |
| Have you had any wisdom teeth extracted?                                   | <input type="checkbox"/> |   |                          |
|  |                          |   |                          |
| Do you expect to keep your natural teeth throughout your lifetime?         | <input type="checkbox"/> | Would you prefer to utilize nitrous oxide (laughing gas) during your dental visits? | <input type="checkbox"/> |
| Do you WANT to keep your natural teeth throughout your lifetime?           | <input type="checkbox"/> | Are you PROUD of your present smile?  | <input type="checkbox"/> |

If you could wave a magic wand to improve your smile, what would you change about your mouth or teeth? \_\_\_\_\_  
 \_\_\_\_\_

DIANE *Arel* DDS MAGD