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PERIODONTICS AND DENTAL IMPLANT SURGERY

Dental History

Patient Name:

What is the reason for your visit? _____

_____

Who referred you to our practice? _____

Referring Dentist: _____ Telephone _____

Address: _____ City: _____ State: _____ Zip: _____

Date of last dental cleaning: _____ How often do you have cleanings? _____

How often do you brush your teeth? _____ How often do you floss? _____

Do you use other dental cleaning aids? (toothpicks, automatic toothbrush) _____

Are you having any dental problems now? **YES** **NO**

If so, please describe: _____

Are your teeth sensitive to:

Hot or cold?	YES	NO
Sweets?	YES	NO
Biting or chewing?	YES	NO
Have you noticed any mouth odors or bad tastes?	YES	NO
Do you frequently get cold sores, blisters or any other oral lesions?	YES	NO

Do your gums bleed or hurt? **YES** **NO**

Have your parents experienced gum disease or tooth loss?	YES	NO
Have you noticed any loose teeth or change in your bite?	YES	NO
Does food tend to become caught in between your teeth?	YES	NO

If yes, where: _____

Do you:

Clench or grind your teeth while awake or asleep?	YES	NO
Bite your lips or cheeks regularly?	YES	NO
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	YES	NO
Mouth breath while awake or asleep?	YES	NO
Have tired jaws, especially in the morning?	YES	NO
Smoke or chew tobacco?	YES	NO

Have you ever had:

Orthodontic treatment?	YES	NO
Oral Surgery?	YES	NO
Periodontal treatment?	YES	NO
Your teeth ground or the bite adjusted?	YES	NO
A bite plate or mouth guard?	YES	NO
A serious injury to the mouth or head?	YES	NO

If so, please describe, including cause: _____

_____

Have you experienced:

Clicking or popping of the jaw?	YES	NO
Pain (joint, ear, side of face)?	YES	NO
Difficulty in opening or closing the mouth?	YES	NO
Difficulty in chewing on either side of the mouth?	YES	NO
Headaches, neckaches, or shoulder aches?	YES	NO
Sore muscles (neck, shoulders)?	YES	NO

Are you satisfied with the appearance of your teeth?	YES	NO
Would you like to keep your teeth all of your life?	YES	NO
Do you feel nervous about having dental treatment?	YES	NO
Have you ever had an upsetting dental experience?	YES	NO

If yes, please describe: _____

_____

Is there anything else about having dental treatment that you would like us to know? **YES** **NO**

If yes, please describe: _____

_____

_____

_____

_____