DENTAL HISTORY

HOW FREQUENTLY HAVE YOU HAD YOUR TEETH CLEANED DURING THE PAST 5 YEARS: (Circle One)

LESS THAN ONCE A YEAR ONCE A YEAR TWICE PER YEAR 3 TIMES A YEAR 4 TIMES A YEAR

MONTH/YEAR OF YOUR LAST DENTAL EXAM: _____ X-RAYS: _____

ARE YOU PRESENTLY SATISFIED WITH THE CONITION OF YOUR MOUTH AND TEETH (CIRCLE ONE):

VERY SATISFIED SATISFIED IT'S OKAY SOMEWHAT DISSATISFIED VERY DISSATISFIED

YES	NO	
☐	☐	DO YOU PRESENTLY HAVE ANY PAIN, DISCOMFORT OR IMPAIRED FUNCTION RELATED TO YOUR MOUTH?
		IF YES, PLEASE DESCRIBE? _____
☐	☐	ARE YOU CURRENTLY AWARE OF ANY INFECTION IN YOUR MOUTH?
		IF YES, PLEASE DESCRIBE: _____
☐	☐	ARE YOU CURRENTLY TAKING ANY ANTIBIOTICS FOR INFECTION? IF SO, WHAT: _____
☐	☐	DO YOUR GUMS EVER BLEED? IF SO, WHEN: _____
☐	☐	DO YOU HAVE A PROBLEM WITH BAD BREATH OR HAVE ANY FRIENDS OR FAMILY MADE YOU AWARE OF THIS?
☐	☐	ARE YOU INTERESTED IN REPLACING LOST TEETH?
☐	☐	DO YOU EVER HAVE ACHES AND PAINS IN YOUR JAW JOINTSS, EARS, FACE, NECK OR HEAD?
☐	☐	ARE ANY AREAS OF YOUR TEETH MORE TENDER WHEN YOU CHEW HARD FOODS?
☐	☐	ARE ANY OF YOUR TEETH MORE SENSITIVE TO: COLD, HOT, SWEETS, CERTAIN FOODS OR DRINKS?
☐	☐	ARE ANY PARTICULAR TEETH VERY SENSITIVE OR PAINFUL?
☐	☐	ARE YOU CONCERNED ABOUT GUM RECESSION AROUND ANY OF YOUR TEETH?
☐	☐	ARE YOU CONCERNED ABOUT THE APPEARANCE OF YOUR TEETH OR MOUTH?
☐	☐	HAVE YOU EVER HAD ORTHODONTIC TREATMENT? WITH BRACE WITH REMOVABLE APPLIANCES
		WHEN DID YOU GO THROUGH ORTHODONTIC CARE? _____
☐	☐	HAVE YOU EVER HAD PERIODONTAL TREATMENT? SCALING / ROOT PLANING GUM SURGERY
		WHEN DID YOU GO THROUGH PERIODONTAL CARE? _____

CHECK ANY OF THE FOLLOWING THAT DESCRIBE YOU OR MAKES DENTAL TREATMENT EASIER FOR YOU:

YES	NO	
☐	☐	I TOLERATE MOST DENTAL CARE REASONABLY WELL AND USUALLY REQUIRE MINIMAL USE OF ANESTHESIA
☐	☐	I APPRECIATE THE USE OF LOCAL ANESTHETIC – IT ALLOWS ME TO TOLERATE MOST DENTAL CARE REASONABLY WELL
☐	☐	I TOLERATE SHOTS IN MY MOUTH WHEN THEY ARE GIVEN WELL
☐	☐	I LIKE THE BENEFITS OF NITROUS OXIDE (LAUGHING GAS)
☐	☐	I PREFER TO BE SEDATED FOR ANY SURGICAL TREATMENT
☐	☐	I PREFER TO BE SEDATED FOR ANY LENGTHY SURGICAL CARE
☐	☐	I HAVE A HARD TIME SITTING IN THE DENTAL CHAIR FOR MORE THAN AN HOUR
☐	☐	I HAVE A HARD TIME SITTING IN THE DENTAL CHAIR VERY LONG DUE TO A NECK, BACK, SPINE PROBLEM
☐	☐	I HAVE DIFFICULTY WHEN TILTED BACK IN THE DENTAL CHAIR (DIZZINESS, BREATHING DIFFICULTY)

WHAT ARE YOUR PRIORITIES FOR THE HEALTH, FUNCTION AND APPEARANCE OF YOUR TEETH & MOUTH:

(RATE EACH ITEM FROM 1 TO 5 WITH 1 BEING YOUR LOWEST PRIORITY & 5 BEING YOUR HIGHEST)

_____ BE ABLE TO CHEW FOOD AND EAT WHAT I ENJOY

_____ PRESERVE MY TEETH AND AVOID DENTURES

_____ BE FREE OF INFECTION

_____ BE FREE OF MOUTH PAIN & TENDERNESS

_____ AVOID REMOVABLE BRIDGEWORK

_____ FOR MY MOUTH TO LOOK NICE WHEN I SMILE

_____ MAKE MY TEETH LOOK GOOD

_____ HAVE A HEALTHY AND HASSLE-FREE MOUTH

_____ SIGNATURE OF PATIENT

_____ DATE

_____ REVIEWED BY: