DENTAL HISTORY

Why did you come to the dentist today? _____

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

When was your last cleaning? _____

Did you have xrays at that time? ❑ Yes ❑ No

How often do you: Brush_____ Floss_____

Type of bristles on your toothbrush? (Circle) Hard Medium Soft

Do you do anything else to clean your teeth? ❑ Yes ❑ No

If yes, what? _____

Do your gums bleed? ❑ Yes ❑ No

Have you ever had gum disease? ❑ Yes ❑ No

Have you ever had rootplaning or a deeper cleaning? ❑ Yes ❑ No

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

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

Do you or have you ever eperienced pain/discomfort in your jaw Joint (TMJ/TMD)? ❑ Yes ❑ No

Are you aware of any clenching or grinding? ❑ Yes ❑ No

Do you have frequent headaches? ❑ Yes ❑ No

Do you have any problems eating certain foods? ❑ Yes ❑ No

If yes, what? _____

Are your teeth sensitive to hot, cold or anything else? _____

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

Do you have any mobility in your teeth? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

If yes, why? _____

If you could change one thing about your smile what would it be? _____

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:_____ Signature: _____
2. Date:_____ Comments:_____ Signature: _____
3. Date:_____ Comments:_____ Signature: _____
4. Date:_____ Comments:_____ Signature: _____
5. Date:_____ Comments:_____ Signature: _____
6. Date:_____ Comments:_____ Signature: _____
7. Date:_____ Comments:_____ Signature: _____
8. Date:_____ Comments:_____ Signature: _____
9. Date:_____ Comments:_____ Signature: _____
10. Date:_____ Comments:_____ Signature: _____

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