DENTAL HEALTH HISTORY

WHEN WAS YOUR LAST DENTAL EXAMINATION: ____

ARE YOU BOTHERED WITH ANY OF THE FOLLOWING?

__ TENDER GUMS WHILE CHEWING __ BLEEDING GUMS __ BAD BREATH __ SORE AREAS IN YOUR MOUTH

__ PAIN IN OR NEAR EARS __ SPACE DEVELOPING BETWEEN TEETH __ SENSITIVITY TO HOT, COLD, SWEETS

ARE YOU HAVING ANY PAIN OR DISCOMFORT AT THIS TIME: YES OR NO

HAVE YOU BEEN TREATED BY A PERIODONTIST (GUM SPECIALIST) YES OR NO

HAVE YOU BEEN TREATED BY AN ORTHODONTIST YES OR NO

ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH YES OR NO

IF NOT WHY: ____

DO YOU WISH TO MAINTAIN YOUR TEETH AND AVOID DENTURES YES OR NO

HAVE MISSING TEETH BEEN REPLACED YES OR NO

DO YOU DRINK COFFEE, TEA, AND / OR POP YES OR NO

IF YES, HOW MUCH AND HOW OFTEN: ____

HAVE YOU EVER HAD NITROUS OXIDE ANALGESIA (GAS) YES OR NO

HAVE YOU HAD A BAD EXPERIENCE IN THE DENTAL OFFICE YES OR NO

DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT YES OR NO

WHAT FRIGHTENS YOU IN THE DENTAL OFFICE: ____

DENTAL CARE DESIRE:

__ HYGIENE __ CAVITIES RESTORE __ EXTRACTIONS __ MISSING TEETH REPLACED

__ DENTURES/ PARTIALS __ ORTHODONTICS __ OTHER: ______________________

HOME CARE

HOW OFTEN DO YOU BRUSH YOUR TEETH: ____

HOW OFTEN DO YOU FLOSS:____

WHAT KIND OF BRUSH DO YOU USE: __ MANUAL __ ELECTRIC

WHAT TEXTURE OF BRUSH DO YOU USE: __ SOFT __ MEDIUM __ HARD __ NYLON __ NATURAL

DO YOU SUFFER FROM MIGRAINES: YES OR NO

DO YOU SNORE: YES OR NO

TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE INFORMATION IS CORRECT. I WILL INFORM YOU IF ANY CHANGES IN MY HEALTH OR MEDICATIONS SHOULD OCCUR.

SIGNATURE: ____ DATE: ____________________________