DENTAL HISTORY

Has your dental care been: Regular ____ Infrequent _____ only when in pain _____

How many times per year do you have your teeth cleaned _____ date of last cleaning _____

Which dentist (s) have you seen in the past 5 years: _____

Are you afraid to go to the dentist Yes ___ No ___ Why _____

Are you satisfied with the appearance of your teeth: Yes___ No____ Why Not _____

Have you had previous gum care Yes___ No___ with whom and When _____

What procedures did you have done_____ _Dental Implants Yes___ No ___

Root Cleaning Yes___ No ___ Gum Surgery/ Grafts Yes____ No ___

Have you had your teeth straightened / braces Yes___ No___ when & with Whom _____

Have you experienced any of the following:

Y N Bleeding gums	Y N Loose teeth	Y N Bad breath
Y N Swelling of gums	Y N Shifting of teeth	Y N Food packed between teeth
Y N Pain/ Soreness of gums	Y N Fever blisters	YN Canker sores
Y N Pus around teeth	Other: _____	

Do you suffer from:

Y N pain Jaw joint	Y N Headaches	Y N Pain in face or neck
Y N Clicking / Popping in joint	Y N Grinding of teeth	Y N Clenching
Y N Sore facial muscles	Other: _____	

Are your teeth sensitive to:

Y N Hot Y N Cold Y N Biting/ Pressure Y N Brushing teeth Y N Sweet

How often do you brush your teeth each day _____ How often do you floss _____

Are you using any dental aids to clean your teeth Yes___ No___

___ Toothpick ___Perio Aid ___ Flouride ___Water Pik ___Proxi Brush

___Electric toothbrush Other: _____

Family members:

Gum Problem Yes___ No___ Lost several teeth Yes___ No ___ Wear Dentures Yes__ No___

Currently, who is your General Dentist _____