ADULT DENTAL HISTORY

PATIENT'S NAME_____

1. Purpose of initial visit_____
2. What is your chief concern or problem?_____
3. How long since your last dental visit?_____
4. What was done at that time?_____
5. Previous dentist's name_____

Address:_____Tel. ( )_____

6. When was the last time your teeth were cleaned?_____
7. Have you ever had any serious trouble associated with previous dental treatment?_____

_____

8. Does dental treatment make you nervous?
   _____No _____Slightly _____Moderately _____Extremely
9. Have you ever been treated for periodontal disease (gum disease) or had periodontal surgery?_____If so, when?_____

CIRCLE THE APPROPRIATE ANSWER, IF YOU ARE UNSURE, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

10. Have you made regular visits? ..... Yes No
11. Were dental x-rays taken? ..... Yes No
12. Have you lost any teeth or have any teeth been removed? ..... Yes No
    Why? _____
13. Have they been replaced? Yes No
    If so, how and date of placement. Fixed bridge_____Denture/partial_____Implant_____
14. Are you unhappy with the replacement? Yes No
    If yes, explain _____
15. Would you like to know about permanent replacements? ..... Yes No
16. Have you ever had a problem or complications with previous dental treatment? ... Yes No
    If yes, explain _____
17. Have you experienced any pain or soreness in the muscles on your face or around your ear? ..... Yes No
18. Do you have frequent headaches, neck aches, or shoulder aches? ..... Yes No
19. Are any of your teeth loose, tipped, shifted or chipped? ..... Yes No
20. Are you unhappy with the appearance of your teeth? ..... Yes No
21. How do you feel about your teeth in general? .....
22. Are you pleased with the shade/color of your teeth..... Yes No
23. Are you interested in whitening your teeth? ..... Yes No
24. Are you interested in shaping or aligning your teeth? ..... Yes No
25. Do you feel your breath is offensive at times? ..... Yes No

Do you have any of the following:

Yes	No	Bleeding, sore gums	Yes	No	Sensitive to hot
Yes	No	Unpleasant taste/bad breath	Yes	No	Sensitive to cold
Yes	No	Burning tongue/lips	Yes	No	Sensitive to sweets
Yes	No	Swelling/lumps in mouth	Yes	No	Sensitive to biting
Yes	No	Ortho treatments (braces)	Yes	No	Food impaction
Yes	No	Biting cheeks/lips	Yes	No	Clenching/grinding
Yes	No	Clicking/popping jaw	Yes	No	Change in bite
Yes	No	Difficulty opening or closing jaw	Yes	No	Injury to head/face
Yes	No	Pain in your jaw.	Yes	No	Reaction to anesthetic

ORAL HYGIENE

Do you use the following?

Yes No Brush
Yes No Floss

How often do you brush_____
Brush is:____Soft____Medium____Hard

To the best of my knowledge, all of the preceding answers are true and correct.

_____ _____
Signature of Patient, Parent or Guardian Date

ANES_____ MED ALERT_____