ADULT DENTAL HISTORY

1. Purpose of initial visit? _____

_____

2. Are you aware of any dental problems?..... YES NO
If yes, please explain _____
3. How long since your last dental visit? _____
4. What was done at that time? _____

_____
5. What is your previous dentist's name? _____
Address _____
Telephone ( ) _____
6. Have you made regular visits to a dentist?..... YES NO
How often? _____
7. Were dental x-rays taken?..... YES NO
8. Have you lost any teeth?..... YES NO
Why? _____
9. Have any lost teeth been replaced?..... YES NO
10. How have these teeth been replaced?
Fixed bridge (When: _____)
Removable bridge (When: _____)
Denture (When: _____)
11. Are you happy with the replacement(s)?..... YES NO
If no, explain _____
12. Have you ever had any problems with previous dental treatment?..... YES NO
If yes, explain _____
13. Do you clench or grind your teeth?..... YES NO
14. Does your jaw click or pop?..... YES NO
15. Do you have pain or soreness in the muscles of your face or around your ear?..... YES NO
16. Do you have frequent headaches, neck aches or shoulder aches?..... YES NO
17. Does food get caught between your teeth?..... YES NO
18. Circle any of the following that your teeth are sensitive to:
hot cold sweets pressure
19. Do your gums bleed or hurt?..... YES NO
When? _____
20. How often do you brush your teeth? _____ When? _____
21. Do you use dental floss?..... YES NO
How often? _____
22. Are any of your teeth loose, tipped, or shifted?..... YES NO
23. Do you have any discolored teeth that bother you?..... YES NO
24. Do you feel your breath is offensive at times?..... YES NO
25. Have you ever had gum treatment or surgery?..... YES NO
When? _____
26. Do you feel good about your teeth in general?..... YES NO
27. Are you happy with the appearance of your teeth?..... YES NO
28. Have you had any unpleasant dental experiences?..... YES NO
29. List anything about dentistry that you strongly dislike: _____

_____
30. Do you have any dental questions or concerns?..... YES NO

Doctor's Notes

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

_____
Patient's Signature Date

_____
Dentist's Signature Date

ANEST.	**MED. ALERT**