Brenden & Brenden

ADULT DENTAL HISTORY

REASON FOR VISIT:

What is the reason for your dental visit today? **EXAMINATION** **EMERGENCY** **CONSULTATION** **PROCEDURE**

Specify: _____

PAST DENTAL TREATMENT:

YES NO DK Have you been to the dentist before?

If yes, how long ago was your last dental exam? **0-6 MONTHS** **6-12 MONTHS** **1-2 YEARS** **> 2 YEARS**

If yes, how long ago was your last dental x-ray? **0-6 MONTHS** **6-12 MONTHS** **1-2 YEARS** **> 2 YEARS**

If yes, how long ago was your last dental cleaning? **0-6 MONTHS** **6-12 MONTHS** **1-2 YEARS** **> 2 YEARS**

YES NO DK Do you have a history of tooth extraction or oral surgery?
(Specify): **EXTRACTIONS** **IMPLANTS** **JAW SURGERY** **TMJ SURGERY** **TRAUMA**

YES NO DK Have you had any periodontal (gum) treatments? (Specify): **DEEP CLEANING** **SURGERY**

YES NO DK Do you have bridges or wear dentures or partials? (Specify): **BRIDGES** **DENTURES** **PARTIALS**

YES NO DK Have you ever had root canal treatment?

YES NO DK Have you ever had orthodontic (braces) treatment?

YES NO DK Have you had a local anesthetic (Lidocaine) for dental purposes?

YES NO DK If yes, have you experienced any problems? (needle anxiety, hard to get numb, etc.)

YES NO DK Have you had any problems associated with previous dental treatment?

YES NO DK Has fear ever prevented you from seeking dental care?

DENTAL PROBLEMS (SIGNS/SYMPTOMS):

YES NO DK Are you currently experiencing dental pain or discomfort?
If yes, is it causing headaches, earaches or neck pains? (Specify): **HEADACHES** **EARACHES** **NECK PAINS**

YES NO DK Are your teeth sensitive to cold, hot, sweets or pressure? (Specify): **COLD** **HOT** **SWEETS** **PRESSURE**

YES NO DK Do you have problems with eating? (Specify): **TROUBLE CHEWING** **SWALLOWING** **VOMITING** **OTHER**

YES NO DK Do you have swelling in or around your mouth, face or neck? (Specify): **MOUTH** **FACE** **NECK**

YES NO DK Do you have loose teeth?

YES NO DK Do you have any clicking, popping, discomfort, or limited opening in the jaw?
(Specify): **CLICKING** **POPPING** **DISCOMFORT** **LIMITED OPENING**

YES NO DK Do you have or have you had sores or ulcers in your mouth? If yes, location:_____

YES NO DK Have you ever injured your face, jaws or teeth?

YES NO DK Are you unhappy with your smile or the appearance of your teeth?

YES NO DK Do you have a bad taste or bad breath? (Specify): **BAD TASTE** **BAD BREATH**

YES NO DK Do you experience dry mouth?

DENTAL DISEASE PREVENTION (ORAL HYGIENE):

How often and when do you brush your teeth? **NEVER** **SOMETIMES** **1x/WEEK** **1x/DAY** **2x/DAY** **> 2x/DAY** **AM** **PM**

How often do you floss your teeth? **NEVER** **SOMETIMES** **1x/WEEK** **1x/DAY** **> 1x/DAY**

Do your gums bleed when you brush or floss? **NEVER** **SOMETIMES** **ALWAYS**

ORAL HABITS:

YES NO DK Do you clench, brux, or grind your teeth? (Specify): **CLENCH** **BRUX/GRIND** **BOTH**

YES NO DK Do you chew on ice or potentially damaging objects (pencils, bottle caps, etc)? (Specify): **ICE** **OBJECTS** **BOTH**