Gladnick FAMILY & COSMETIC DENTISTRY

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Dental History

Patient Name: ____

What is the reason for your visit today?____
Date of last dental visit _____________ Last dental cleaning _____________ Last Full Mouth X-Rays ______________
What was done at your last dental visit? ____

Previous Dentist's Name ____Telephone________________________

How often do you have dental examinations? ____
How often do you brush your teeth? ________________________ How often do you floss? ______________________
What other cleaning aids do you use? (waterpik,toothpick,etc.)____

Do you have any dental problems now? Yes No
If yes, please describe: ____

Are any of your teeth sensitive to Hot / Cold / Sweets? . . . . Yes No
Have you noticed any mouth odors or bad tastes? . . . . Yes No
Do you frequently get cold sores, blisters or any other oral lesions? . . . Yes No

Do your gums bleed or hurt? . . . . Yes No
Have you noticed any loose teeth or change in your bite? . . . . Yes No
Does food tend to become caught in between your teeth? . . . . Yes No
If yes, where? ______________________________

Do you:
Clench or grind your teeth while awake or asleep . . . . Yes No
Bite your lips or cheeks regularly . . . . Yes No
Hold objects with your teeth (pencils, pins, nails, fingernails) . . . . . Yes No
Mouth breathe awake/asleep . . . . . . Yes No
Have tired jaws, especially in the Morning . . . . Yes No
Snore or have sleeping disorders . . . Yes No
Smoke/chew tobacco products . . . . Yes No

Have you ever had:
Orthodontic treatment . . . . Yes No
Oral surgery . . . . Yes No
Periodontal treatment . . . . Yes No
Your teeth ground or bite adjusted . . . Yes No
Night Guard . . . . Yes No
A serious injury to the mouth, head . . Yes No
If yes, please describe__________________________
____

Have you experienced:
Clicking or popping of the jaw . . . . Yes No
Pain (joint, ear, side of face) . . . . Yes No
Difficulty opening or closing mouth . . . Yes No
Difficulty chewing on either side . . . . . Yes No
Head, neck or shoulder pain . . . . Yes No
Sore muscles (neck, shoulders) . . . . Yes No

Are you satisfied with your teeth's appearance?
Yes No
If so, what is your biggest concern? ________________
____

Do you feel nervous about dental treatment?
Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe ____

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