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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