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PERIODONTICS & IMPLANTOLOGY

ADULT DENTAL HISTORY

TODAY'S 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? Please circle below:
0-6 MONTHS 6-12 MONTHS 1-2 YEARS >2 YEARS
If yes, how long ago were your last dental x-rays? Please circle below:
0-6 MONTHS 6-12 MONTHS 1-2 YEARS >2 YEARS
If yes, how long ago was your last dental cleaning? Please circle below:
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 Partial
- 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 local anesthetic (lidocaine) for dental purposes?
YES NO DK If yes, have you experienced any problems? (needle anxiety, hard to numb, ect)
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- YES NO DK Have you had any problems associated with previous dental treatment?
- YES NO DK Has fear ever prevented you from seeking dentalcare?

DENTAL PROBLEMS (Signs/Symptoms)

- YES NO DK Are you currently experiencing dental pain or discomfort?
If yes, is it causing headaches, earaches or neck pain?
Specify: Headaches Earaches Neck Pain
- 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? Please circle below:
Specify: Trouble Chewing Swallowing Vomiting Other
- YES NO DK Do you have swelling in or around your mouth, face, 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

ADULT DENTAL HISTORY (Cont.)

DENTAL PROBLEMS

- 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? Please circle below:
Never Sometimes 1 x Week 1 x Day AM 1 x Day PM 2 x Day > 2 x Day
- How often do you floss your teeth? Please circle below:
Never Sometimes 1 x Week 1 x Day > 1 x Day
- Do your gums bleed when you brush or floss? Please circle below:
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