ADULT DENTAL HISTORY

PATIENT NAME _____

Have you had Orthodontic treatment? ___ Yes ___ No

Have you had Oral surgery? ___ Yes ___ No Gum treatment? ___ Yes ___ No

PROBLEMS OF THE JAW

Do you have a night guard? ___ Yes ___ No Do you grind or clench your teeth? ___ Yes ___ No

Has your bite been adjusted? ___ Yes ___ No

Does your jaw click? ___ Yes ___ No

Do you difficulty opening or closing your jaw? ___ Yes

Do you have difficulty chewing? ___ Yes ___ No

Have you injured your head, neck or jaw? ___ Yes ___ No

TEETH, GUM, OR MOUTH ISSUES

Does food frequently get caught between your teeth? ___ Yes ___ No

Do your gums often bleed while brushing? ___ Yes ___ No

Have you noticed loosening of your teeth? ___ Yes ___ No

Do you have a dry mouth? ___ Yes ___ No

Are you having dental pain? ___ Yes ___ No

Do you have any sores or swelling in your mouth? ___ Yes ___ No

DENTAL TREATMENT

Date of last dental x-rays _____ Date of last dental treatment _____

Date of last dental cleaning _____

Have you had any difficulty with dental treatment or anesthetic?

Reason for today's visit _____