Fairview Park Dental Care

DENTAL HISTORY

Patient Name:_____ Date:_____

1. Reason for visit / Main concern? _____

2. Are there other conditions we should be aware of? YES_____NO_____

   If yes, please specify: _____

3. When did you last visit a dentist? _____

4. What treatment was performed?_____

5. Was the treatment completed? YES_____NO_____

6. Were dental Xrays taken? YES_____NO_____

7. Did you have a cleaning at this time? YES_____NO_____ If not, when was your last cleaning?_____

8. Have you had gum (periodontal) treatment or a deep cleaning? YES_____NO_____

9. Have you ever had prolonged bleeding after an extraction? YES_____NO_____

   If yes, please specify:_____

10. Have you had any problems with past dental treatment? YES_____ NO_____

    If yes, please explain:_____

11. Has a doctor ever told you that you need to take antibiotics before dental treatment? YES_____NO_____

12. Do you grind your teeth, clench your jaws, or have jaw joint symptoms such as clicking, popping, pain or locking open? YES_____NO_____

13. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES_____ NO_____ Do you wear a guard? YES_____ NO_____

    If yes, please explain:_____

14. Do your gums bleed easily? YES_____NO_____

15. Do you feel you have bad breath? YES_____NO_____

16. Are your teeth sensitive to hot or cold? YES_____NO_____

17. Have you had braces? YES_____ NO_____ If yes, do you wear a retainer YES_____NO_____

18. Would you like your teeth whiter? YES_____NO_____

19. Are you happy with your smile? YES_____NO_____

    If no, please explain what you don't like:_____