Adult Dental History

☐ **YES** ☐ **NO** Are you having dental pain?
☐ **YES** ☐ **NO** Do you have toothaches?
☐ **YES** ☐ **NO** Are our teeth frequently sensitive?
☐ **YES** ☐ **NO** Do you have a burning/scalding feeling in your tongue, mouth or lips?
☐ **YES** ☐ **NO** Do you have a bad taste or mouth odor?
☐ **YES** ☐ **NO** Do you have fever blisters, mouth ulcers, or sores in your mouth or lips?
☐ **YES** ☐ **NO** Have you ever had any serious trouble associated with any previous dental treatment?
☐ **YES** ☐ **NO** Does your mouth seem to be too full of saliva?
☐ **YES** ☐ **NO** Do you have a coating on your tongue?
☐ **YES** ☐ **NO** Do you have chapped lips?
☐ **YES** ☐ **NO** Do you frequently have cracks/raw places at the corners of you mouth?
☐ **YES** ☐ **NO** Do you frequently notice that your mouth/lips are dry?
☐ **YES** ☐ **NO** Do you have difficulty swallowing?
☐ **YES** ☐ **NO** Do you think you teeth are affecting your health?
☐ **YES** ☐ **NO** Do you think that you have decayed teeth (cavities)?
☐ **YES** ☐ **NO** Are you having difficulty chewing food?
☐ **YES** ☐ **NO** Do you desire to avoid dentures as long as possible?
☐ **YES** ☐ **NO** Do you have gumboils or abscesses?
☐ **YES** ☐ **NO** Are your gums frequently sore or tender?
☐ **YES** ☐ **NO** Do you think that you have gum trouble?
☐ **YES** ☐ **NO** Have you been treated for gum disease?
☐ **YES** ☐ **NO** Do you have a tooth/teeth that frequently seem loose?
☐ **YES** ☐ **NO** Do you have bleeding gums after brushing your teeth?
☐ **YES** ☐ **NO** Do you have bleeding gums after eating?
☐ **YES** ☐ **NO** Do you seem to have bleeding from the mouth for no apparent reason (Example, is there blood on your pillow on arising)?
☐ **YES** ☐ **NO** Are your gums shrinking away from your teeth?
☐ **YES** ☐ **NO** Do you have teeth that seem to be shifting in position?
☐ **YES** ☐ **NO** Do you notice popping, clicking, or soreness of the j jaws or points just in front or your ears?
☐ **YES** ☐ **NO** Do you have pain around your ears, eyes, head, neck?
☐ **YES** ☐ **NO** Do you clinch or grind your teeth, or are you conscious of the way your teeth fit together, awake or asleep?
☐ **YES** ☐ **NO** When you wake up are your teeth clamped together or do they feel sore?
☐ **YES** ☐ **NO** Do you have pain, lumps, or swelling of the face/jaws?
☐ **YES** ☐ **NO** Have you had difficulty with extractions or other operations (excessive bleeding, swelling, infection or nausea)?
☐ **YES** ☐ **NO** Following injuries or dental treatment, have you had bleeding problems?
☐ **YES** ☐ **NO** Has a dentist told you that you had a dry socket?
☐ **YES** ☐ **NO** Have you ever had any injury to your face or jaws?
☐ **YES** ☐ **NO** Have you ever had surgery or x-ray treatment for a tumor, growth, or other condition in your mouth/lips?
☐ **YES** ☐ **NO** Have you lost any teeth because of dental decay?
☐ **YES** ☐ **NO** Have you lost any teeth because of periodontal

☐ **YES** ☐ **NO** Were teeth extracted for any other reason?
☐ **YES** ☐ **NO** Have your missing teeth been replaced?
☐ **YES** ☐ **NO** Are you happy with the replacement?
☐ **YES** ☐ **NO** Do you frequently wedge food between your teeth?
☐ **YES** ☐ **NO** Has a dentist told you that you have one or more nonvital (dead) teeth or have you had a root canal?
☐ **YES** ☐ **NO** Have you worn braces for straightening your teeth?
☐ **YES** ☐ **NO** Do you press your tongue against your teeth?
☐ **YES** ☐ **NO** Do you bite your lip, check, fingernails, or objects such as pencils?
☐ **YES** ☐ **NO** Do you chew or smoke tobacco in any form?
☐ **YES** ☐ **NO** Do you smoke more than half a pack of cigarettes daily?
☐ **YES** ☐ **NO** Are you dissatisfied with the appearance of your teeth?
☐ **YES** ☐ **NO** Would you like to have straighter teeth?
☐ **YES** ☐ **NO** Do you brush your teeth less than once a day?
☐ **YES** ☐ **NO** Do you use such dental aids as toothpicks, dental loss, or irrigation sprays less than once a day?
☐ **YES** ☐ **NO** Do you use a hard-bristle toothbrush?
☐ **YES** ☐ **NO** Are your teeth stained?
☐ **YES** ☐ **NO** Does calculus (tartar) form rapidly on your teeth?
☐ **YES** ☐ **NO** Have you usually had your teeth cleaned once a year?
☐ **YES** ☐ **NO** Have you been told how to brush and floss your teeth?
☐ **YES** ☐ **NO** Do you chew gum or suck on mints almost daily?
☐ **YES** ☐ **NO** Do you consume sweets/drinks between meals?
☐ **YES** ☐ **NO** Do you drink coffee/tea more than three times a day?
☐ **YES** ☐ **NO** Do you consume soft drinks almost daily?
☐ **YES** ☐ **NO** Do you frequently skip breakfast?
☐ **YES** ☐ **NO** Are you interested in dietary or nutritional counseling?

On a scale of 1-5: 1-Very Much, 2-Moderately, 3-Neutral, 4-Somewhat, and 5-Not at all, please answer the following questions.

1 2 3 4 5 How much anxiety do you feel at the dentist?
1 2 3 4 5 How much pain have you experienced in previous dental treatment?
1 2 3 4 5 How much have you neglected your dental treatment?
1 2 3 4 5 To what degree has your past experience of pain affected your compliance with dental care?
1 2 3 4 5 Have you ever cancelled or not appeared for dental appointments?

What is the date of your last examination and x-rays?_____
What is your present dental problem?_____
Please add any comments that you feel will assist the dental team in our concern for your treatment_____
_____
_____
Authorized Signature:_____
Date:_____