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## 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?
0-6 MONTHS 6-12 MONTHS 1-2 YEARS >2 YEARS
If yes, how long ago were your last dental x-rays?
0-6 MONTHS 6-12 MONTHS 1-2 YEARS >2 YEARS
If yes, how long ago was your last dental cleaning?
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 Partials

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?
If yes, have you experienced any problems? (needle anxiety, hard to numb, ect)
______________________________

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?
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?
Never Sometimes I x Week I x Day AM I x Day PM 2 x Day > 2 x Day

How often do you floss your teeth?
Never Sometimes I x Week I x Day > I x Day

Do your gums bleed when you brush or floss?
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