Dental history

Why have you come to the dentist today? ____________________________

Are you currently in pain?

Yes/No

Do you require antibiotics before dental treatment?

Yes/No

Your current dental health is:

Good   Fair   Poor

Have you ever had a serious/difficult problem associated with any previous dental work?

Yes/No

Do you floss daily?

Yes/No

Brush daily?

Yes/No

Type of bristles on your toothbrush?

Hard  Medium  Soft

Have you ever had gum treatment?

Yes/No

Do your gums ever bleed?

Yes/No

Ever Itch?

Yes/No

Have you ever had periodontal disease?

Yes/No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?

Yes/No

Are your teeth sensitive to

Heat   Cold   anything else?

If not, what would you change?

Signature: ________________________ Date: ______________

OFFICE USE ONLY

(YEAR 1) Initials: ___________________ Date: _______________

(YEAR 2) Initials: ___________________ Date: _______________

(YEAR 3) Initials: ___________________ Date: _______________

Year 2: Changes in health

Date: __________________ Signature: __________________

Year 3: Changes in health

Date: __________________ Signature: __________________

Health questionnaire must be updated each year

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Update of Dental/Medical History