DENTAL HISTORY

CURRENT GENERAL DENTIST _____

DATE OF LAST DENTAL VISIT _____ LAST DENTAL CLEANING _____ LAST FULL MOUTH X-RAYS _____

HOW OFTEN DO YOU HAVE DENTAL EXAMINATIONS? _____*Seldom* _____ *Less than annually* _____ *Annually* _____ *Twice Annually or More*

HOW OFTEN DO YOU BRUSH YOU TEETH? _____ **HOW OFTEN DO YOU FLOSS?** _____

WHAT OTHER DENTAL AIDS DO YOU USE? (Mouthrinse, toothpick, etc.) _____

Have you ever had:

Periodontal Treatment (deep cleaning or gum surgery)? ..... Yes No..... If yes, when? _____

Oral Surgery (tooth removal)? ..... Yes No

Orthodontic Treatment (braces)? ..... Yes No ..... If yes, when? _____

Your teeth ground or the bite adjusted? ..... Yes No

A bite plate or mouth guard? ..... Yes No

Do you smoke or chew tobacco? ..... Yes No..... If yes, how much? _____

Do you clench or grind your teeth while awake or asleep? .....Yes No

Has any of your family members experienced periodontal disease (such as gum disease or gingivitis)? ..... Yes No..... If yes, which family members? _____

Have you noticed any loose teeth or a change in your bite? .....Yes No _____

Do you mouth-breathe while awake or asleep? .....Yes No

Does food tend to become caught in between your teeth? .....Yes No..... If yes, where? _____

Do you have tired jaws, especially in the morning?.....Yes No _____

Do you regularly experience clicking, popping or pain in the jaw joints?.....Yes No

Do you have difficulty in opening or closing your mouth? .....Yes No

Do you chew on objects such as pencils or bite your nails? ..... Yes No..... If yes, what objects? _____

Would you like to keep all of your teeth all of your life? ..... Yes No

Do you feel nervous about having dental treatment? ..... Yes No..... If yes, what is your main concern? _____

_____

Have you ever had an upsetting dental experience? ..... Yes No..... If yes, please describe: _____

_____

Have you ever been told you need to take premedication prior to dental treatment? _____

Please explain anything else about having dental treatment that you would like us to know? _____

_____

_____

I understand that my medical and dental histories are necessary to provide me with periodontal care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, Dr. Amra Spahic-Musakadic has my permission to ask the respective health care provider or agency, who may release such information to Dr. Amra Spahic-Musakadic. I will notify Dr. Amra Spahic-Musakadic of any change in my health and/or medication(s).

Patient/Guardian's Signature _____ **Date** _____