Port Warwick DENTAL ARTS
COMPREHENSIVE DENTISTRY FOR TOTAL WELLNESS, FUNCTION AND BEAUTY

Adult Dental Health History

Scientific research states that dental disease strongly affects total health. We are commited to helping you maintain a healthy mouth for a healthy body.

Name_____Age_____Date of Birth_____

Do you have dental pain or discomfort now? Y N

If yes, describe:

What would you like done today?

Approximately when was your last Dental check-up and cleaning?
Month: Year: [ ] Not sure

How would you describe your present state of dental health:
[ ] Excellent [ ] Good [ ] Fair [ ] Poor

Are you anxious about dental treatment? To what extent:
[ ] Mildly [ ] Moderately [ ] Severely [ ] Not at all

Have you ever had any ill effects from injections of Novocaine or Xylocaine (local anesthetics)? Y N

Have you ever had prolonged bleeding or complications after extractions? Y N

If yes, describe:

Do you have any tooth sensitivities?
[ ] Hot [ ] Cold [ ] Sweets [ ] None

Do you have a present or past history of smoking cigars or cigarettes? Y N

If yes, how often?

Do you have a present or past history of vaping, using snuff, smokeless tobacco or marijuana? Y N

If yes, which one(s) and how often?

When last used?

Do you experience bad breath and/or an unpleasant taste in your mouth? Y N

Do you have a history of sinus problems or drainage? Y N

Are you a mouth breather? Y N

Has anyone ever mentioned that you snore? Y N

Have you noticed swelling or lumps in your mouth? Y N

If yes, describe:

Do you have frequent blisters or ulcers:
[ ] On your lips [ ] Inside your mouth [ ] No problems

Do your gums:
[ ] Bleed [ ] Feel tender [ ] Hurt [ ] No problems

Have you ever had **non-surgical** periodontal gum treatment in any of these forms?
[ ] Deep scaling [ ]Root planing [ ] Laser [ ] No

If yes, when?

Have you ever had **surgical** periodontal gum treatment? Y N

If yes, when? Describe:

Have you ever had orthodontic treatment (braces)? Y N

If yes, year completed:

Do you have a habit of biting:
[ ] Fingernails [ ] Cheeks [ ] Lips [ ] No

Do you clench or grind your teeth?
[ ] When tense [ ] When angry [ ] While asleep [ ] No

Do you awaken with headaches or suffer from migranes?
[ ]Yes [ ]No

Have you noticed any issues with your jaw?
[ ] Popping [ ] Clicking [ ] Soreness [ ] No

Have you ever had treatment for TMJ/MPD joint or muscular problems of the jaw? Y N

If yes, when? Describe:

Approximately how often do you brush your teeth?

What type of toothbrush do you use?
[ ] Hard [ ] Medium [ ] Soft [ ] Not sure

Approximately how often do you floss your teeth?

Do you use fluoride supplements at home?
[ ] Rinse [ ] Gels [ ] Vitamins [ ] Drops [ ] No

Do you use picks or brushes to clean between your teeth?
[ ] Plastic Toothpicks [ ] Proxy brush [ ] Other [ ] No

Do you use any other device for cleaning your teeth?
[ ] Water jet [ ] Electric toothbrush [ ] Other [ ] No

Are you unhappy with the appearance of your teeth? Y N

Would you like your smile to look different? Y N

If yes, describe:

Do you think you would be disturbed if you had to lose your teeth and wear false teeth? Y N

Have you been seeing a dentist on a regular basis? Y N

Dentist Name: City/State:

Reason for leaving:

I hereby certify that the above medical, dental and emergency information is correct to the best of my knowledge, and I will inform the Doctor of Dentistry if any changes occur.

Patient's Signature: _____

Printed Name: _____

Date: _____

Doctor's Signature: _____