Laketown Dental

Family · Implant · Cosmetic · Orthodontics

Dental History Form

Overview:

Yes	No	Is it important for you to keep your teeth?
Yes	No	Are you satisfied with the appearance of your teeth?
Yes	No	Are you satisfied with the function of your teeth?
Yes	No	Does food frequently get caught between your teeth?
Yes	No	Do your gums often bleed while brushing?
Yes	No	Have you ever injured your head, neck or jaw?
Yes	No	Have you ever had trauma to your face, mouth or teeth?
Yes	No	Do you have difficulty eating or swallowing?
Yes	No	Do you ever experience dry mouth?
Yes	No	Do you have any concerns about mouth odor?
Yes	No	Are you happy with the way your teeth look when you smile?
Yes	No	Are you happy with the color of your teeth?
Yes	No	Do you have any spaces between your teeth you are unhappy with?
Yes	No	Are you happy with the way your teeth fit together when you bite?
Yes	No	Do you have any old fillings or treatment you are unhappy with?

Problems of the jaw...Have you noticed:

Yes	No	Clicking of the jaw?
Yes	No	Pain (joint, ear, side of face)?
Yes	No	Difficulty opening or closing?
Yes	No	Difficulty chewing?

Oral Habits...Do you:

Yes	No	Clench or grind your teeth?
Yes	No	Bite your cheeks or lips frequently?

Have you had:

Yes	No	Orthodontic treatment? (Braces)
Yes	No	Oral Surgery?
Yes	No	Gum treatment/Periodontal treatment?
Yes	No	A bite guard or other mouth appliance?
Yes	No	BOTOX treatment or dermal fillers?

Do you currently have:

Yes	No	Dental pain?
Yes	No	Sores or swelling in your mouth?
Yes	No	A partial or full denture?
Yes	No	Dental Implants?
Yes	No	Fluoride in your water or supplement your diet with fluoride?

Sleep Medicine:

Yes	No	Have you been told or are you aware you have a tendency for snoring?
Yes	No	Do you feel rested in the morning?
Yes	No	Do you feel like you're "dragging " during the day?

Medications:

Yes	No	Have you ever taken a medication for osteoporosis or any other bone condition?

Additional Information:

What is your biggest obstacle to dental treatment?

How do you feel about your teeth? (wear, broken, appearance)

Is there anything you would change about your teeth or smile? What would it be?

When was your last dental treatment?

When was your last dental cleaning?

Date of last dental x-rays?

How often do you brush your teeth?

How often do you floss?