Stummer Dental and Sleep Medicine Center

DENTAL HISTORY
FOR

_____

When was the last time you were seen by a dentist ? _____
How many times a day do you brush your teeth? _____
How many times a day do you floss? _____
What type of toothbrush do you use? ___ Manual (soft med or hard bristle)___ Electric ___ Both
If you wear dentures or partial dentures, when were they placed? _____
Are your teeth sensitive to any of the following: ___ Hot/Cold ___ Sweets ___ Biting/Chewing

PLEASE CHECK ALL THAT YOU WOULD ANSWER "YES."

_____ Do you require pre-medication when visiting the dentist?
_____ Do you have any dental problems now or feel pain to any of your teeth?
If yes, please describe: _____
_____ Are you using any other dental devices (i.e. retainer, bite guard etc.)?
If yes, please describe: _____
_____ Do you have any sores or lumps in or near your mouth?
_____ Do your gums ever bleed while brushing or flossing?
_____ Does food tend to become caught in between your teeth?
_____ Do you clench or grind your teeth?
_____ Do you bite your lips or cheeks frequently?
_____ Do you hold foreign objects with your teeth (pencils, pipes, fingernails, etc.)?
_____ Do you have tired jaws, especially in the morning?
_____ Have you ever had orthodontic treatment (i.e. braces, retainer, etc.)?
Have you ever had any of the following? (If yes, please describe.):
_____ Oral Surgery_____
_____ Periodontal Treatment_____
_____ Your bite adjusted_____
Have you ever experienced any of the following?:
_____ Clicking or popping of the jaw
_____ Pain in joint, ear, side of face
_____ Difficulty opening or closing the mouth
_____ Difficulty chewing on either side of the mouth
_____ Sore or aching facial muscles
_____ A difficult tooth extraction
_____ Prolonged bleeding following an extraction

If you could change anything about your smile, what would it be?

_____

Is there anything else about having dental treatment that you would like us to know?

_____

_____

To the best of my knowledge, I have answered the questions on this history accurately
It is my responsibility to inform this office of any change to my medical/dental status.

SIGNATURE_____DATE_____
patient, parent, guardian or custodian