

Patient Dental History

When was your last visit to the dentist? _____

Date of last x-rays? _____

What treatment was performed? _____

TMD:

Y	N	<u>Conditions</u>
<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent headaches?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain in or around the right jaw joint?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain in or around the left jaw joint?
		When is the pain worse?: <u>Mornings/Evenings/At meals/No specific time</u>
<input type="checkbox"/>	<input type="checkbox"/>	Do you have clicking, popping, or grating noise in your right jaw joint?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have clicking, popping, or grating noise in your left jaw joint?
<input type="checkbox"/>	<input type="checkbox"/>	Has your mouth ever locked open so you were unable to close it?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had problems opening your mouth wide?
<input type="checkbox"/>	<input type="checkbox"/>	Are you aware of clenching your teeth? When? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you grind your teeth? When? _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking, or have you taken, medication for this problem? _____

PERIO:

Home Care:

Y	N	<u>Conditions</u>		Times per day
<input type="checkbox"/>	<input type="checkbox"/>	Do you have bleeding when brushing or flossing?	Brushing:	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have red, swollen or tender gums?	Flossing:	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have receding gums?	Mouthwash:	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you previously been diagnosed with gum disease?		

SMILE EVALUATION:

Y	N	<u>Conditions</u>
<input type="checkbox"/>	<input type="checkbox"/>	Do you like the way your teeth look?
<input type="checkbox"/>	<input type="checkbox"/>	Would you like your teeth to be whiter?
<input type="checkbox"/>	<input type="checkbox"/>	Would you like your teeth to be straighter?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have spaces between your teeth that you would like closed?
<input type="checkbox"/>	<input type="checkbox"/>	Would you like your teeth to be longer?
<input type="checkbox"/>	<input type="checkbox"/>	Do you like the shape of your teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have missing teeth that you would like to replace?
<input type="checkbox"/>	<input type="checkbox"/>	Would you like to replace old silver fillings with tooth-colored fillings?

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