GAITHER PERIO
DENTAL HISTORY

Dental History

What is the reason for your visit today? _____

_____

Date of last Dental Visit? _____ Last Cleaning? _____ Last set of X-rays? _____

What was done at your last visit? _____

Current Dentist's Name? _____ Telephone? _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are you currently using any fluoride products? **Y or N**

What other dental aids do you use (Interpak, toothpick, etc.)? _____

Are any of your teeth sensitive to:

Hot or cold?..... **Y or N**

Sweets? ..... **Y or N**

Biting or chewing? ..... **Y or N**

Have you noticed any mouth odors
Or bad taste?..... **Y or N**

Do you frequently get cold sores
Blisters or any other lesions?..... Y or N

Have your parents experienced gum disease
Or tooth loss?..... Y or N

Have you noticed any loose teeth or change in
Your bite?..... Y or N

Do You:

Clench or grind your teeth while awake
Or asleep?..... Y or N

Bite your lips or cheeks regular.....Y or N

Hold foreign objects in your mouth
(pencils, pipe, nails, etc.) ..... Y or N

Mouth breathe while wake or asleep?..... Y or N

Have tired jaws especially in the morning? Y or N

Snore or have any other sleeping
Disorders?..... Y or N

Do you use Tobacco products?..... Y or N

If yes, what type and how often_____
_____.

Have you ever had:

Periodontal treatment?.....**Y or N**

If yes, what type and when? _____

_____

Your teeth ground or bite adjusted?..... Y or N
A bite plate or mouth guard?..... Y or N
A serious injury to the mouth or head?..... Y or N
If yes, please explain? _____
_____

Have you ever experienced:

Clenching or popping of the jaw?..... Y or N
Pain (joint, ear, side of face)?..... Y or N

Difficulty in opening or closing mouth?... Y or N

Difficulty in chewing on either side of
the mouth?..... Y or N

Headaches, neck aches or shoulder
aches?..... Y or N

Would you like to keep all your teeth all
all your life?..... Y or N

Have you ever been told to pre- med prior
to dental treatment?..... Y or N

If yes, explain_____
_____.