Menlo-Park-Dental-Excellence-DENTAL HISTORY

Baseline Examination

Date of your last visit to a dentist: _____

Reason for your last visit (or series of visits): _____

Do you have any x-rays and/or photos of your dental records? ☐ Yes ☐ No ☐ Not Sure

Approximately when were these x-rays and/or photos taken? _____

In respect to any previous dental treatment, have you…? (Please check one answer)

1) Ever fainted? ☐ Yes ☐ No ☐ Not Sure
2) Had an allergic reaction? ☐ Yes ☐ No ☐ Not Sure
3) Had abnormal bleeding? ☐ Yes ☐ No ☐ Not Sure
4) Had any other complications during or following dental treatment? ☐ Yes ☐ No ☐ Not Sure
   If yes, please describe: _____
5) Do your gums bleed when brushing, flossing or eating? ☐ Yes ☐ No ☐ Not Sure
6) Does food catch between your teeth? ☐ Yes ☐ No ☐ Not Sure
7) Have your teeth shifted, or are there spaces between your teeth now where there were none, or are your teeth flaring, or are some of your teeth becoming loose? ☐ Yes ☐ No ☐ Not Sure
8) Are any of your teeth sensitive to heat, cold and/or pressure? ☐ Yes ☐ No ☐ Not Sure
9) Do you grind your teeth or clench your jaws? ☐ Yes ☐ No ☐ Not Sure
10) Do you have pain or clicking in the jaw joint around your ear? ☐ Yes ☐ No ☐ Not Sure
11) Have your jaw muscles ever sore? ☐ Yes ☐ No ☐ Not Sure
    If yes, please describe: _____
12) Are there any sores or growths in your mouth? ☐ Yes ☐ No ☐ Not Sure
13) Do any of your teeth ache? ☐ Yes ☐ No ☐ Not Sure
14) Do you have any problems chewing gum or bagels? ☐ Yes ☐ No ☐ Not Sure
15) Have your teeth changed within the last five years? ☐ Yes ☐ No ☐ Not Sure
16) Do you have trouble sleeping? ☐ Yes ☐ No ☐ Not Sure
17) Do you notice your teeth grinding, clenching or worn? ☐ Yes ☐ No ☐ Not Sure
18) Do you have any other dental concerns? _____

Appliances

1) Do you have any fixed non removable bridges in your teeth? ☐ Yes ☐ No ☐ Not Sure
   ☐ Upper or ☐ Lower ☐ Left or ☐ Right
2) Do you have any removable dentures? ☐ Yes ☐ No ☐ Not Sure
3) Do you have any retainer for Invisalign or regular braces? ☐ Yes ☐ No ☐ Not Sure
4) Do you have any splints, stents, sport mouth guard, hard or soft night guard? ☐ Yes ☐ No ☐ Not Sure

Please note that any change in your health status should be reported to our office at the earliest possible time.
To the best of my knowledge, the above-mentioned questions have been accurately answered.

Signature: _____ Date: _____