Professional Periodontics and Dental Implants

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Dental History

Name:_____ Birthdate:_____

Are you experiencing any discomfort at this time? ……	Yes	No
Do you experience bleeding or painful gums? …….....	Yes	No
Have you had any teeth extracted because of periodontal (gum) disease? ……	Yes	No
Have you ever had periodontal treatment? ……..	Yes	No
If yes, when and by whom? _____		
Do you have parents or siblings who have had gum disease or lost their teeth? ….	Yes	No
Are you aware of any loose teeth? ……	Yes	No
Do you frequently have an unpleasant odor or taste in your mouth? ……..	Yes	No
Are your teeth sensitive to hot, cold, or sweets? …….	Yes	No
Would you be disturbed if you had to lose your teeth? …….....	Yes	No
Have you ever had orthodontic treatment (braces)? ……...	Yes	No
Do you often clench or grind your teeth? ……..	Yes	No
Do you see a dentist on a regular basis? ……..	Yes	No
When were your teeth last cleaned? _____		
How often do you have your teeth cleaned? _____		
How often do you brush your teeth? _____		

What type of toothbrush do you use? SOFT MEDIUM HARD (circle)

Other oral hygiene aids: Dental Floss Toothpick Electric Toothbrush Other