Dr. Todd Dakin DENTISTRY

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DENTAL HISTORY

Are you experiencing any dental problems?	Yes ☐ No ☐
Date of your last dental visit:	
Dental cleaning:	
X-rays:	

		YES	NO
1.	Have you been seeing a dentist regularly?	☐	☐
2.	Are there any growths or sore spots in your mouth?	☐	☐
3.	Have you noticed any loose teeth, or have any of your teeth shifted?	☐	☐
4.	Does food get caught between your teeth?	☐	☐
5.	Are any of your teeth sensitive to heat, cold, sweets or pressure?	☐	☐
6.	Do you use dental floss, proxabrush, or stimudents?	☐	☐
	How often?		
7.	How often do you brush your teeth?		
	- Do you feel that you have bad breath?	☐	☐
8.	Have you ever had one of the following?		
	- Periodontal treatment? (treatment of the gums)	☐	☐
	- Orthodontic treatment? (to straighten or realign teeth)	☐	☐
	- A bite plate or any other appliance?	☐	☐
	- Your bite adjusted or teeth ground?	☐	☐
	- Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?)	☐	☐
9.	JAW PROBLEMS - Do you have any of the following?		
	- Popping/clicking in your jaw joints?	☐	☐
	- Pain in your jaw joints, around your ear, or side of your face?	☐	☐
	- Difficulty in opening or closing?	☐	☐
	- Pain when teeth are clenched?	☐	☐
	- Pain/difficulty in chewing?	☐	☐

	- Tension or migraine headaches?	☐	☐
10.	Do you have any of the following habits?		
	- Clenching or grinding your teeth while awake or asleep?	☐	☐
	- Biting your cheeks or lips regularly?	☐	☐
	- Hold foreign objects with your teeth (pencils, nails, pipes, pins, fingernails)?	☐	☐
11.	Do you have any emotional concerns or anxiety about having dental treatment?	☐	☐
	- Would the use of nitrous oxide for dental procedures be of interest to you?	☐	☐
12.	Are you happy with the appearance of your teeth?	☐	☐
	If no, what would you like to see changed? or chose from the choices below:		
	- Straighter teeth (i.e., orthodontic braces or prosthetic straightening with crowns or veneers)	☐	☐
	- Whiter teeth (i.e., tooth bleaching or prosthetic veneers)	☐	☐
	- Correction of worn, chipped, or cracked teeth	☐	☐
	- Replacement of missing teeth	☐	☐
	- Correction of gingiva (i.e., too much gum tissue showing, swollen or puffy gums)	☐	☐
13.	Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or do you have any questions or concerns?	☐	☐