OAK PARK DENTAL

Enhancing your life, health and smile.

DENTAL HEALTH HISTORY

Patient Name:_________________________ DOB:______________ Today's Date:______________

How do you feel about dental treatment? ❍ Relaxed ❍ A bit uneasy ❍ Tense ❍ Anxious ❍ Very Anxious ❍ Major Phobia

Reason for seeking dental care at this time? ____

____

Are there any other concerns or questions you have about your dental health that you would like the Doctor to address today?

____

How often do you brush and floss?

BRUSH 1 • 2 • 3+ Per: Day / Week / Month / Never
FLOSS 1 • 2 • 3+ Per: Day / Week / Month / Never

Date of last dental visit?____________ Date of last dental x-rays?____________ Previous Dentist:____________

Have you ever whitened your teeth? ❍ Yes ❍ No Are you interested in whitening your teeth? ❍ Yes ❍ No

Please check the following items you have:

❍ Fixed Bridge ❍ Partial Denture ❍ Dentures ❍ Dental Implants ❍ Veneers ❍ Gum Surgery ❍ Jaw Surgery
❍ Orthodontics (braces) ❍ Root Canal ❍ Same Day Crown (Cerec) ❍ C-PAP Machine/Sleep Appliance

Please answer Yes or No to the following:

Sensitivity to hot or cold.......❍ Yes ❍ No
Teeth sensitive to sweets.......❍ Yes ❍ No
Sore or bleeding gums.......❍ Yes ❍ No
Bite lips or cheeks.......❍ Yes ❍ No
Periodontal disease.......❍ Yes ❍ No
Missing teeth.......❍ Yes ❍ No
Toothaches.......❍ Yes ❍ No
Mouth breathing.......❍ Yes ❍ No
Offensive/bad breath.......❍ Yes ❍ No
Snoring (or have been told you snore).......❍ Yes ❍ No
Sensitive to metals.......❍ Yes ❍ No
Unfavorable dental experience.......❍ Yes ❍ No
Grinding/clenching of teeth.......❍ Yes ❍ No
History of TMJ-Splint Therapy.......❍ Yes ❍ No
Clicking/popping of jaw.......❍ Yes ❍ No

Difficulty opening/chewing.......❍ Yes ❍ No
Unsightly spaced teeth.......❍ Yes ❍ No
Crooked/tipped teeth.......❍ Yes ❍ No
Growth(s)/lesions in mouth.......❍ Yes ❍ No
Swollen glands.......❍ Yes ❍ No
Broken filling(s).......❍ Yes ❍ No
Does jaw pain affect your daily routine?.......❍ Yes ❍ No
Cold sores/oral lesions.......❍ Yes ❍ No
Catch food between teeth.......❍ Yes ❍ No
Discolored teeth.......❍ Yes ❍ No
Loose teeth.......❍ Yes ❍ No
Chipped or broken teeth.......❍ Yes ❍ No
Wear dentures or partials.......❍ Yes ❍ No
Is your bite uncomfortable or uneven?.......❍ Yes ❍ No
Dissatisfied with appearance of your teeth?.......❍ Yes ❍ No
Sleep apnea.......❍ Yes ❍ No

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If you could change something about the look or feel of your smile/teeth, what would it be?

- Whiter teeth ❍
- Straighter teeth ❍
- Replace missing teeth ❍
- Replace old mismatched crowns ❍
- Replace unnatural looking dark fillings ❍
- I don't want to be embarrassed to smile in front of people ❍
- Head, neck, jaw injuries ❍
- Repair chipped teeth ❍
- Other ❍

______________________ ______________________ ______________________ ______________________

______________________ ______________________ ______________________ ______________________

On a scale of 1-10, with 10 being the highest,

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

What matters most to you in your overall dental health? ______________________

Everyone likes to hear information in different ways. How would you like to hear your dental health information?

Bottom Line   Brief Detail   Some Detail   Lots of Detail

______________________ ______________________

Patient/Guardian Signature   Date

______________________ ______________________

Print Name   Relationship to Patient