Fallbrook Family Dentistry

DENTAL HISTORY

Please describe your chief oral complaint:

_____

_____

_____

	Yes	No
Are your teeth sensitive to:		
Heat?	___	___
Cold?	___	___
Sweets?	___	___
Chewing?	___	___
Do you have any food traps?	___	___
Do your gums ever feel tender or swollen?	___	___
Do your gums bleed when brushing?	___	___
Do you have any teeth that feel loose?	___	___
Have you been treated for periodontal disease?	___	___
Do you use dental floss?	___	___
Have you had any injuries to your face or jaw?	___	___
Have you ever had your teeth straightened/braces?	___	___
Do you clench or grind your teeth?	___	___
Do you strike some teeth before others when closing?	___	___
Have you ever had your bite adjusted?	___	___
Do your jaws ever feel tired or ache?	___	___
Can you chew comfortably?	___	___
Have you had a complete dental exam including full mouth x-rays in the past 3 years?	___	___
Do you have your teeth cleaned regularly?	___	___
When was your last cleaning?	___	___
Do you have all your natural teeth?	___	___
Would you like to keep your natural teeth?	___	___
Are missing teeth replaced?	___	___
Do you like the appearance of your smile?	___	___
Do you consider yourself a nervous patient?	___	___
Have you ever had a bad dental experience?	___	___
Have you had issues with local anesthetics?	___	___

Physician's Name_____ __ Phone #_____

Last visit to physician_____ Last Complete Physical_____

If you could change your teeth/smile, how would you? _____

_____

_____

_____

When was your last dental visit? _____

What was done at that visit? _____

_____

Where was it done? _____