Name_____ **Adult Dental History**

Print Name

COMMENTS

1. Purpose of initial visit? _____
   _____
2. Are you aware of any problems? _____
   _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. What is your previous dentist's name? _____
   _____
   Address Telephone
6. Have you made regular visits to a dentist?.....YES NO
   How often? _____
7. Were dental X-rays taken?.....YES NO
8. Have you lost any teeth? ..... YES NO
   Why? _____
9. Have they been replaced? .....YES NO
10. How have they been replaced?
    a. Fixed bridge_____ Age_____
    b. Removable bridge _____ Age_____
    c. Denture _____ Age_____
11. Are you happy with the replacement? .....YES NO
12. If no, please explain _____
13. Have you ever had any problems or complications with previous dental treatment?.....YES NO
    If yes, please explain_____
14. Do you clench or grind your teeth?.....YES NO
15. Does your jaw click or pop? .....YES NO
16. Have you experienced any pain or soreness in the muscles of your face or around your ear? .....YES NO
17. Do you have frequent headaches, neckaches or shoulder aches? .....YES NO
18. Does food get caught between you teeth? .....YES NO
19. Are any of your teeth sensitive to hot ____cold____sweets____pressure____
20. Do your gums bleed or hurt? .....YES NO
    When? _____
21. How often do you brush your teeth?_____ When_____
22. Do you use dental floss?.....YES NO
    How often? _____
23. Are any of your teeth loose, tipped or shifted? .....YES NO
24. Do you have any discolored teeth that bother you? .....YES NO
25. Do you feel your breath is offensive at times? .....YES NO
26. Have you ever had gum treatment or surgery? .....YES NO
    When? _____
27. How do you feel about your teeth in general? _____
    _____
28. Are you happy with the appearance of your teeth? .....YES NO
29. Have you had any unpleasant dental experiences or anything about dentistry that you strongly dislike?
    _____
    _____
30. Do you have any questions or concerns? .....YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE_____ DATE_____

DENTIST'S SIGNATURE_____ DATE_____

ANEST.

MED. ALERT

Sunnyside Family Dentistry 11808 SE Sunnyside Rd.
503-698-1112 • Fax: 971-224-5027 • info@myclackamasdentist.com