

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