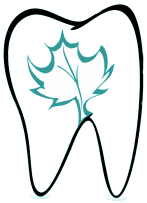
ADVANCED DENTAL SERVICES of Jacksonville

DENTAL HISTORY



Date: _____

Name: _____ Date Of Birth: _____ Age: _____
Last First Middle

In the following section, circle the appropriate responses. Your answers are for our records and will be considered confidential.

1) Have you ever required antibiotic premedication for dental treatment? .... YES NO

2) Have you had an allergy or adverse reaction to dental anesthetics? ..... YES NO

3) When was your last dental exam and cleaning (approximate)? _____

4) Please answer the following questions about your current dental condition:

a) Do you brush regularly? ..... YES NO
b) Do you floss regularly? ..... YES NO
c) Are you experiencing any pain/symptoms with your teeth? ..... YES NO
d) Have you noticed increased sensitivity with your teeth? ..... YES NO
e) Do you have any fractured or broken teeth? ..... YES NO
f) Are you aware of any cavities that you might have? ..... YES NO
g) Have you experienced any pain/symptoms with your gums? ..... YES NO
h) Do your gums bleed easily? ..... YES NO
i) Do you have a habit of grinding your teeth? ..... YES NO
j) Have you noticed that your jaw joints pop, grind, or click? ..... YES NO
k) Do you have soreness in your jaw joints (TMJ)? ..... YES NO
l) Do you experience frequent headaches? ..... YES NO
k) Have you had dental work in the past? ..... YES NO
l) Do you have anxiety as it relates to dental treatment? ..... YES NO
m) Have you used sedation for dental treatment? ..... YES NO
n) Do you have complete or partial dentures? ..... YES NO
- If yes, are you interested in improving their fit? ..... YES NO
o) Do you currently use a mouth guard/bite guard? ..... YES NO
p) Are you happy with the color of your teeth? ..... YES NO
q) Are you happy with the appearance of your teeth? ..... YES NO
r) Is there anything you would like to change about your teeth? ..... YES NO

Please Explain:

Name (Print) Signature Date