Andrew G. Gilfillan, D.D.S.

DENTAL HISTORY

Patient's Name_____ Birth Date_____

Reason for today's visit_____

When was your last dental visit?_____ What was done then?_____

How often did you visit the dentist before then?_____

Have you had a complete series of dental x-rays taken? □ Yes □ No If so, when?_____

How often do you brush your teeth?_____ How often do you floss?_____

Is your drinking water fluoridated?_____ Do you have city water or well water?_____

If you could change anything about the appearance of your smile, what would you change?_____

_____

Please discuss any additional dental concerns you may have:_____

_____

Please answer all of the following questions by checking the appropriate box:

Do you feel pain in any area of your mouth?..... □Y □N
If so, where and how long has this been a problem?_____
Do you have any sores, bumps or lumps in or around your mouth?..... □Y □N
Are your teeth sensitive to hot or cold?..... □Y □N
Are your teeth sensitive to sweets?..... □Y □N

Are any of your teeth missing?..... □Y □N
If so are you interested in replacement options?.... □Y □N
Do you wear full or partial dentures?..... □Y □N
Do you have difficulty chewing due to missing teeth?..... □Y □N

Have you ever had the following jaw problems:
Clicking or popping?..... □Y □N
Pain in jaw joint, ear or side of face?..... □Y □N
Difficulty opening wide?..... □Y □N
Jaw locking open?..... □Y □N
Do you have frequent headaches?..... □Y □N
Do you clench or grind your teeth?..... □Y □N
Have you ever had treatment for "TMJ"?..... □Y □N
Do you or have you ever worn a night guard or bite plate? ..... □Y □N

Have you had any head, neck or jaw injuries?..... □Y □N
Have you ever had prolonged bleeding after extractions or any other dental treatment?..... □Y □N
Have you had any bad experiences with past dental treatment?..... □Y □N
Has fear or anxiety kept you from receiving needed dental treatment?..... □Y □N

Have you ever been told you have periodontal disease (gum disease)?..... □Y □N
Have you ever had treatment for periodontal disease?..... □Y □N
Do your gums bleed while brushing or flossing?..... □Y □N
Do you have any loose teeth?..... □Y □N
Do you have areas where food gets caught?..... □Y □N
Do you have concerns about bad breath?..... □Y □N

Are you unhappy with the appearance of your teeth?..... □Y □N
Have you ever had your teeth bleached?..... □Y □N
Have you ever had your teeth restored for cosmetic purposes?..... □Y □N
Are you interested in options to change or improve the appearance of your teeth?..... □Y □N