2120 17th Ave
Longmont, CO 80501
Tel: (303) 776-6021

# DENTAL HISTORY

**Patient Name:**_______________________________________________________**Date**: ______________________

Primary reason for this dental appointment: ____ Examination ____ Emergency ____ Consultation

The following information is important, because we want to be thorough in understanding you and your present or future problems. This way, we may better serve your oral health needs. Our objective is to help you to be well in the future, as well as now. *Please Circle*

| | |
|---|---|
| Do you have a specific dental Problem? Describe__________________________________________________ | Yes No |
| Do you have dental examinations on a routine basis? Last Visit______________________________________ | Yes No |
| Have you been satisfied with your past dentistry? _________________________________________ | Yes No |
| Previous Dentist:______________________________City__________________________________________ | |
| Do you think you have active decay or gum disease? | Yes No |
| Do you have: Bad Breath ______Bad Taste _______ When?________________________________________ | No |
| Do you brush and floss on a regular basis?_____ How often? _____________________________________ | Yes No |
| Have you had your gums treated (periodontal therapy)? When?___________________________________ | Yes No |
| Tooth sensitivity? What and where? ____________________________________________________________ | Yes No |
| Are you aware of grinding or clenching your teeth? When?_______________________________________ | Yes No |
| Do you have: Noises when opening or closing your jaw?_________________________________________ | Yes No |
| Do you smoke cigarettes? ____ Chew tobacco?____ Drink Coffee?_____ Cups per day______ | No |

| Do you eat: | Daily | X/Week | X/Month | |
|---|---|---|---|---|
| Candy | ____ | _____ | _____ | Yes No |
| Cookies, cake etc. | ____ | _____ | _____ | Yes No |
| Soft drinks | ____ | _____ | _____ | Yes No |
| Red Meat | ____ | _____ | _____ | Yes No |
| Chicken, turkey, fish | ____ | _____ | ____ | Yes No |
| Fresh fruit | ____ | _____ | _____ | Yes No |
| Vegetables | ____ | _____ | _____ | Yes No |

Do you take vitamin or mineral supplements? Yes No

What kind?__________________________________________Reason (s) ?_________________________________________

1. Why are you here?
2. Tell me what you do to clean your teeth at home? How often do you brush? Floss?
3. Do you have periodontal problems? Have you had periodontal therapy? Do your gums bleed? When?
4. Do you have any teeth that are sensitive to hot, cold or air? Pressure?
5. Have you noticed any spots or stains on your teeth? Any concerns about appearance?
6. Does tooth loss tend to run in your family? Does that concern you? Are you missing any teeth?
7. Do you have concerns about mercury amalgam fillings?