Jonathan M. Jenkins, D.D.S., M.S.

DENTAL HISTORY

Patient Name	Medical Alert

WELCOME! So that we may provide you with the best possible care, please complete both sides of this Medical-Dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of last dental visit _____ **Last dental cleaning** _____ **Last full mouth x-rays** _____

What was done at your last dental visit? _____

General Dentist's name _____

Referring Dentist _____

How often do you see your dentist? _____

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

What other dental aids do you use? (waterpik, electric toothbrush, toothpick) _____

Do you have dental problems? ❒ Yes ❒ No If yes, please describe _____

_____

Please circle the correct response to:

Are any of your teeth sensitive to:		
Hot or cold	Yes	No
Sweets	Yes	No
Biting or Chewing	Yes	No
Have you noticed any mouth odors or bad tastes	Yes	No
Do you frequently get cold sores, blisters or lesions	Yes	No
Do your gums bleed or hurt	Yes	No
Have your parents experienced gum disease or tooth loss	Yes	No
Have you noticed any loose teeth or change in your bite	Yes	No
Does food tend to get caught between your teeth	Yes	No

If Yes, where _____

_____

Do you clench or grind your teeth	Yes	No
Do you bite your lips or cheeks regularly	Yes	No
Do you hold foreign objects in your teeth	Yes	No
Do you mouth breathe while awake or asleep	Yes	No
More than 2 alcoholic beverages per day	Yes	No
Do you smoke or chew tobacco	Yes	No

What? _____ How much _____

Have you had orthodontic treatment	Yes	No
Have you had oral surgery	Yes	No
Have you had periodontal treatment	Yes	No
Have you had your bite adjusted	Yes	No
Have you had a mouth guard or bite plate	Yes	No
Have you had a serious head or mouth injury	Yes	No

If Yes, please describe, _____

_____

_____

Have you experienced clicking or popping	Yes	No
Have you experienced pain (joint, ear, face)	Yes	No
Have you had difficulty chewing	Yes	No
Have you had headaches or neckaches	Yes	No
Soreness/horseness in throat	Yes	No
Are you satisfied with your teeth's appearance	Yes	No
Would you like to keep your teeth for life	Yes	No
Do you feel nervous about dental treatment	Yes	No

If Yes, what is your biggest concern _____

_____

Have you ever had an upsetting dental experience	Yes	No

If Yes, please describe _____

_____

_____

Is there anything else about having dental treatment that you would like us to know about? Yes No

If yes, please describe _____

(Please complete the other side)