Dr. Nick AbuJamra
PROSTHODONTIC DENTISTRY

DENTAL HISTORY for: _____

What is the reason for your visit today? _____

_____

Do you have any dental problems now? _____ Yes _____ No

If yes, please describe: _____

_____

Date of Last Dental Visit _____ **How often do you have dental examinations?** _____

Referring Dentist's Name _____

Address _____

Telephone _____

What dental aids do you use?

- ○ Floss
- ○ Interplak
- ○ Sonicare
- ○ Waterpik
- ○ Toothpick
- ○ Other _____

Are any of your teeth sensitive to:

Hot or cold?	○ Yes	○ No
Sweets?	○ Yes	○ No
Biting or chewing	○ Yes	○ No
Have you noticed mouth odors or bad taste?	○ Yes	○ No
Do you frequently get cold sores, blisters, or any other oral lesions?	○ Yes	○ No

Do your gums bleed or hurt?

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 become caught in between your teeth?	○ Yes	○ No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	○ Yes	○ No
Bite your lips or cheeks regularly?	○ Yes	○ No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	○ Yes	○ No
Mouth breathe while awake or asleep?	○ Yes	○ No
Have tired jaws, especially in the morning?	○ Yes	○ No
Smoke/chew tobacco?	○ Yes	○ No

Have you ever had:

Orthodontic treatment?	○ Yes	○ No
Oral surgery?	○ Yes	○ No
Periodontal treatment?	○ Yes	○ No
Your teeth ground or the bite adjusted?	○ Yes	○ No
A bite plate or mouth guard?	○ Yes	○ No
A serious injury to the mouth or head?	○ Yes	○ No

If so, please describe, including cause:

_____

Have you experienced:

Clicking or popping of jaw?	○ Yes	○ No
Pain? (Joint, ear, side of face)	○ Yes	○ No
Difficulty in opening/closing the mouth?	○ Yes	○ No
Headaches?	○ Yes	○ No
Sore muscles (neck, shoulders)?	○ Yes	○ No
Difficulty chewing?	○ Yes	○ No
Are you satisfied with your teeth's appearance?	○ Yes	○ No
Would you like to keep all of your teeth all of your life?	○ Yes	○ No
Do you feel nervous about having dental treatment?	○ Yes	○ No

If so, 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? If yes, please describe:

_____

_____

EMERGENCY CONTACT: **Name** _____ **Phone** _____