PLEASE PRINT

Clark College
Dental Hygiene Department

DENTAL HISTORY

Patient Name____Date____________________
LAST FIRST MI

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPOPRIATE RESPONSE OR FILLING IN THE BLANK.

1. In the past two years, have you had any of the following symptoms? ***(If YES, please check all that apply.)***

❑ Sensitive teeth	❑ Sore jaw	❑ Toothache	❑ Sore gums
❑ Bleeding gums	❑ Difficulty chewing	❑ Filling fell out	❑ Dry mouth
❑ Bad breath	❑ Burning sensation	❑ Abscess	❑ Swollen face
❑ Swelling inside mouth	❑ Tartar buildup	❑ Broken teeth	❑ Difficulty swallowing

Comments:____

____

2. In the past two years, how many times have you been to a dental office for:

_______Checkups and cleanings Date of last cleaning:________

Check any dental treatment you have had in the last two years:

❑ Fillings	❑ Dental emergency	❑ Bridges	❑ Implants
❑ Crowns (caps)	❑ Gum treatment	❑ Dentures	

3. When did you last have dental x-rays taken? ______________________________

4. Do you clench or grind your teeth?

❑ YES ❑ NO *If YES,* during the day? ❑ At night? ❑

If YES, do you wear a bite guard? ❑ For how long?_______________ ❑ Don't wear it

5. In the past two years, have you been concerned about the appearance of your teeth?

❑ YES ❑ NO *If YES, please check all that apply.)*

❑ Yellowing/graying teeth ❑ Stains ❑Crowded, crooked teeth ❑Spacing between teeth

Other:____

6. Has anyone in your family lost teeth?

❑ YES ❑ NO

7. Check any of the following you regularly use at home:

❑ Soft toothbrush	❑ Dental floss	❑ Floss threader	❑ Fluoride supplements tabs or drops
❑ Hard toothbrush	❑ Special brush	❑ Toothpick	❑ Powered interdental cleaner
❑ Medium toothbrush	❑ Fluoride toothpaste	❑ Fluoride rinse or gel	❑ Powered brush
❑ Oral irrigator	❑ Rubber tip	❑ Mouth rinse	❑ Other:____________________
❑ Denture adhesive	❑ Denture cleanser	❑ Whitening product	

8. Check the type of toothpaste you use:

❑ Fluoride	❑ Tartar control	❑ Gum benefit	❑ Whitening
❑ Sensitivity protection	❑ Baking soda	❑ Peroxide	❑ Multiple benefit

9. How long does it take you to clean your teeth and gums?

Brushing time____________________________ Flossing or between teeth cleaning time______________________

10. How many times each day/week do you brush and floss?

I brush about ____________times per day.

I floss about ____________times per day.

11. Do you have or have you ever had oral piercings?

❑ YES ❑ NO

12. Is it difficult for you to clean your teeth?

❑ YES ❑ NO *(If YES, please check all that apply.)*

❑ Hold a toothbrush ❑ Use dental floss ❑ Brush/floss for any length of time ❑ Don't see well

13. Do you gag easily?

❑ YES ❑ NO

14. Are you on a fluoridated public water system? *If YES,* for how long?______________________________

❑ YES ❑ NO

15. Do you drink filtered or bottled water most of the time?

❑ YES ❑ NO *If YES,* what type of filter?____________For how long?____________

BEHAVIORS

1. When your health professional recommends a change in health behavior, do you follow this advice?
❑ YES ❑ NO ❑ Sometimes

2. When you are ill, do you:
❑ See your health care provider? ❑ Seek care in an emergency room? ❑ Wait to see if the condition goes away?

3. Are you nervous or apprehensive about dental treatment?
❑ YES ❑ NO ❑ Somewhat *(Explain)*________________

4. Do you feel your stress level has increased in the past six months?
❑ YES ❑ NO ❑ Somewhat *(Explain)*________________

5. Do you use tobacco in any form?
❑ YES ❑ NO ❑ Sometimes
If YES, what type?________ Frequency/Quantity?________ For how long?________

6. Do you consume alcohol?
❑ YES ❑ NO ❑ Sometimes
If YES, what type?________ Frequency/Quantity?________

7. Do you consume caffeine?
❑ YES ❑ NO ❑ Sometimes
If YES, what type?________ Frequency/Quantity?________

8. Do you exercise daily?
❑ YES ❑ NO ❑ Sometimes
If YES, what type?________ Frequency/Quantity?________

9. Do you participate in sports/recreation activities?
❑ YES ❑ NO ❑ Sometimes
If YES, what type?________ Frequency/Quantity?________

10. Do you consume any of the following BETWEEN meals? *(Please check all that apply.)*

❑ Breath mints	Dried fruits	Sugared liquids or juice	Cookies
❑ Cough drops	Antacid tablets	Chips	Other________
❑ Chewing gum	Carbonated beverages	Crackers	

BELIEFS

How likely do you think you are to have cavities or other problems with your teeth and/or gums?
❑ Very likely ❑ Likely ❑ Less likely ❑ Probably never

How important is it for you to prevent cavities, gum problems or other diseases of the mouth?
❑ Very important ❑ Somewhat important ❑ Not at all important

Would you like your hygienist to make specific product recommendations to meet your oral care needs?
❑ YES ❑ I am not sure ❑ NO

I believe that I have control over the condition of my mouth.
❑ YES, firmly believe ❑ Somewhat believe ❑ NO, do not believe

STUDENT	DATE	CHANGES