CRESCENT DENTAL HISTORY

PATIENT _____ DOB_____

Date of your last dental visit _____

Do your gum bleed while brushing or flossing? Yes No

Have you had any fillings done? Yes No

Are your teeth sensitive to hot or cold liquids/ foods? Yes No

Do you feel pain to any of your teeth? Yes No

Do you have any sore or lumps in or near your mouth? Yes No

Have you had any head, neck, or jaw injuries? Yes No

Do you have frequent headaches? Yes No

Do you clench or grind your teeth? Yes No

Do you bite your lips or cheeks frequently? Yes No

Have you ever needed Antibiotics before your dental treatment? Yes No

Have you ever experienced any of the following:

- Clicking in jaw Yes No
- Pain in (joint, ear, side of the face) Yes No
- Difficulty in opening or closing mouth Yes No
- Difficulty in chewing Yes No

Have you had any (Braces) or orthodontic work? Yes No

Have you had prolong bleeding following extraction? Yes No

Have you ever had instruction on the correct method of brushing teeth? Yes No

Have you ever had instruction on the care of your gums? Yes No

Have you had cleaning done every 3 or 4 months? Yes No

When was your last cleaning and x-rays? Date:_____ Yes No

Comments :

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