Victor Drabkin DDS

Dental History

Patient Name _____ **Medical Alert** _____

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? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

How often do you have dental examinations? _____

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

Have you ever used or are you currently using topical fluoride? ❍ Yes ❍ No

What other dental aids do you use? (Electric Toothbrush, toothpick, etc.) _____

Do you have any dental problems now? ❍ Yes ❍ No If yes, please describe: _____

Do you feel nervous about having dental treatment? ❍ Yes ❍ No If yes, please describe: _____

Have you ever had an upsetting dental experience? ❍ Yes ❍ No If yes, please describe: _____

Have you ever been told to take a pre-medication prior to dental treatment? ❍ Yes ❍ No

Is there anything else about having dental treatment that you would like us to know? ❍ Yes ❍ No If yes, please describe: _____

Do you or have you had any of the following?:

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
Clicking or popping of the jaw	❍ Yes	❍ No
Pain? (joint, ear, side of face)	❍ Yes	❍ No
Difficulty in opening or dosing the mouth	❍ Yes	❍ No
Difficulty in chewing on either side of the mouth	❍ Yes	❍ No
Headaches, neck-aches or shoulder aches	❍ Yes	❍ No
Sore muscles (neck, shoulders)	❍ Yes	❍ No
Dry mouth	❍ Yes	❍ No
Gag easily	❍ Yes	❍ No
Lip/Tongue piercing	❍ Yes	❍ No
Wear full/partial dentures	❍ Yes	❍ No
Need to chew on one side of mouth	❍ Yes	❍ No
A serious injury to the mouth or head	❍ Yes	❍ No

Please describe, including cause _____

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 any oral 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 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, etc.)	❍ Yes	❍ No
Mouth breathe while awake or asleep	❍ Yes	❍ No
Have tired jaws, especially in the morning	❍ Yes	❍ No
Snore or have any other sleeping disorders	❍ Yes	❍ No
Smoke/chew tobacco or use other tobacco products	❍ Yes	❍ No

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