

CRESCENT LODGE DENTAL PRACTICE



dental history

DO THESE PROBLEMS APPLY TO YOU

- | | YES | NO | |
|---|--------------------------|--------------------------|-------|
| 1. Tooth pain or discomfort when chewing? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Sensitivity to hot/cold/sweet foods or drinks? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Fractured teeth or fillings? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Grinding or clenching teeth? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Headaches, ear aches, neck pain? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. Bleeding or swollen gums? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 7. Loose or shifting teeth? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 8. Bad breath, or bad taste in the mouth? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

PLEASE GIVE DETAILS

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING

- | | | | |
|---------------------------------|--------------------------|--------------------------|-------|
| 1. Dentures or partial dentures | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Braces | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Dental implants | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Periodental (gum) treatment | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Crowns and bridges | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

PLEASE SHARE THE FOLLOWING DATES

- | | | |
|-------------------------------------|-------------|------------|
| 1. Your last cleaning | Month _____ | Year _____ |
| 2. Your last oral cancer screening? | Month _____ | Year _____ |
| 3. Your last complete x-ray? | Month _____ | Year _____ |

I give consent for photographs to be taken and used for information & training Yes No