Dental History Form

*Welcome to Ely Family Dentistry. We appreciate the confidence you place with us to provide your dental service. To best serve you, please complete the following form. This information is important. If you have any changes to this information, please let us know.*

 *\*If you have any questions, please ask. We are here for you.\**

Answer options : Yes / Sometimes / No

Are you apprehensive about

dental treatment? ------------------------------------Y / S / N

Have you had problems with previous dental

treatment?--------------------------------------------Y / S / N

How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear dentures or partials? ------------- Y / S / N

Are you satisfied with the appearance

of your teeth?---------------------------------------- Y / S /N

Do you gag easily? -----------------------------------Y / S / N

Do you have difficulty chewing?---------------------- Y / S / N

Do you chew only on one side?----------------- Y / S / N

Does food catch between your teeth

easily or more than preferred? ----------------- Y / S / N

Do your gums bleed when you floss? -----------Y / S / N

Do your gums bleed easily?----------------------- Y / S / N

Do your gums feel swollen or tender? ---------Y / S / N

Do you avoid brushing any part of your

mouth due to discomfort?----------------------- Y / S / N

Are your teeth sensitive? -------------------------- Y / S / N

 Hot foods or liquids-------------------------------- Y / S / N

 Cold foods or liquids------------------------------- Y / S / N

 Sour---------------------------------------------------- Y / S / N

 Sweet-------------------------------------------------- Y / S / N

 Pressure---------------------------------------------- Y / S / N

Do you take fluoride supplements?--------------- Y / S / N

Does your jaw make noise when you

 open and/or close?------------------------------------- Y / S / N

Do you clench or grind your jaw frequently?----- Y / S / N

Do you have any jaw, temple pain or

 headaches when you wake up?-------------------- Y / S / N

Do you have a history of TMJ or TMD?------------- Y / S / N

Do you have pain in the face, checks, jaw,

 joints, throat, or temples?---------------------------- Y / S / N

Are you aware of an uncomfortable bite?--------- Y / S / N

Have you had jaw or face trauma? ----------------- Y / S / N

 If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a habitual gum chewer or pipe smoker? Y / S / N

Would you like to know more about

 quitting smoking?------------------------------------ Y / S / N