DiChristofano & DiChristofano
QUALITY DENTISTRY, COMPASSIONATE CARE

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Adult Dental History

Patient's name _____
Last First Initial Date of Birth

1. Previous Dentist _____ Date of last exam _____
2. Purpose of this visit _____
3. Are you aware of a dental problem? _____
4. When was the last time your teeth were cleaned professionally? _____
5. When were X-rays taken last? _____
6. At what month interval were your teeth cleaned? _____

Please check yes or no to the following questions:	Yes	No
7. Have you experienced any problems or complications with previous dental treatment?	☐	☐
8. Do you have any discomfort in your mouth?	☐	☐
9. Do your gums bleed while brushing or flossing?	☐	☐
10. Are your teeth sensitive to hot or cold liquids/or sweet /sour foods?	☐	☐
11. Do you regurgitate your food or have acid reflux?	☐	☐
12. Do you have any sores or lumps in or near your mouth?	☐	☐
13. Have you had any head, neck or jaw injuries?	☐	☐
14. Have you experienced any of the following problems with your jaw ?		
Clicking	☐	☐
Pain(Joint, Ear, Side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

Questions:	Yes	No
15. Do you have frequent headaches or neckaches? ----------	☐	☐
16. Do you clench or grind your teeth? ----------	☐	☐
17. Do you bite your lips or cheeks frequently? ----------	☐	☐
18. Have you ever had any gum treatment or oral surgery? ----------	☐	☐
19. Have you had any difficult extractions in the past? ----------	☐	☐
20. Have you ever had any prolonged bleeding following extractions? ----	☐	☐
21. Have you had any orthodontic treatment? ----------	☐	☐
22. Do you wear dentures or partials? ----------	☐	☐
23. Have you received oral hygiene instructions regarding the care of your teeth and gums? ----------	☐	☐
24. Do you brush your teeth daily? ----------	☐	☐
25. Do you floss your teeth daily? ----------	☐	☐
26. Do you like your smile? ----------	☐	☐
27. Are you happy with the appearance of your teeth? ----------	☐	☐
28. Do you have any questions or concerns? ----------	☐	☐

I certify that the above information is complete and accurate.

Patient's signature _____ Date _____

Dentist's signature _____ Date _____