The Perioclinic
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In order to aid in evaluating your dental health thoroughly and completely, please complete the following questionnaire. This will become part of your office record and will be held in strict confidence. Since periodontal disease is produced by a combination of many complex elements, it is necessary to resolve every possible contributing factor. The success of therapy is dependent upon this. Though some of the following questions may seem unrelated to your gum condition, they are all associated with proper management of your oral health.

DENTAL HISTORY

PATIENT NAME _____ TODAY'S DATE _____
NAME OF REGULAR DDS_____ HOW LONG A PATIENT _____
MAIN DENTAL COMPLAINT OR DENTAL PROBLEM _____

How long have you known about your gum condition? _____

What type of gum treatment have you had previously?
□ None □ Regular cleaning □ Deep cleaning/scaling □ Gum Surgery

When was your last dental cleaning?_____

How many times have you had your teeth cleaned in the last 3 years?_____

Have you lost any teeth?_____ About when _____
If yes, why? _____
Any problems with the tooth extractions? _____

Do you wear any replacement dental prosthesis? _____
Cemented bridges Removable bridges Complete dentures

Have you had bad breath at times?	Yes	No
Have you had bleeding or hurting when you brush or eat?	Yes	No
Have you had pocketing or bone loss around your teeth?	Yes	No
Have you had sensitivity to hot, cold, or sweets?	Yes	No
Does food generally wedge between certain teeth?	Yes	No
Where? _____		
Have you had any of the following dental treatments:		
Orthodontics (braces), if yes, when _____	Yes	No
Endodontics (root canal therapy), if yes, when _____	Yes	No
Oral surgery, if yes, when _____	Yes	No
Has fear or discomfort kept you from regular dental visits?	Yes	No
Do you experience anxiety or gagging during dental procedures?	Yes	No
Have you had any trouble in a dental procedure, including a reaction with anesthetic?	Yes	No
If yes, describe _____		
Are you happy with the appearance of your teeth and/or gums?	Yes	No
If not, why not? _____		

How would you rate your past dental care? _____

Do you have history of early tooth loss in you family?	Yes	No
Does your jaw click, crackle, pop or make grating noises?	Yes	No
Have you experienced any pain or soreness in the muscles of your face or around the ear?	Yes	No
Do you have frequent "tension" headaches?	Yes	No
Do you clench or grind your teeth?	Yes	No
Do your jaws feel stiff, sore or tired when you awaken?	Yes	No
Do your jaws feel tired at the end of the day?	Yes	No
Have you noticed any loose, shifting, or tipped teeth?	Yes	No

Check the items that you use to clean your mouth

		Type if known	How often
Tooth paste	▢	_____	_____
Dental floss	▢	_____	_____
Rubber tip	▢	_____	_____
Toothpicks	▢	_____	_____
Mouthwash	▢	_____	_____
Electric toothbrush	▢	_____	_____
Water Pik	▢	_____	_____
Other	▢	_____	_____

Is there anything else or anything special you think I should know about your dental history? _____

Doctor's Dental History Notes: