LIBERTY CENTER
DENTAL CARE

Patient Dental History

Name ______________________________ Date ______________

Part I. Dental Experiences and Symptoms

1. What is the main reason for your visit?
____

2. When you look inside your mouth, do you know what to look for?

	Yes	No
Tooth decay	❑	❑
Oral Cancer	❑	❑
Gum Disease	❑	❑
Cold Sores	❑	❑

3. Have you had dental X-rays in the past 2 years?
❑ Yes Type ______________ ❑ No

4. Have you had any complications or negative experiences associated with previous dental treatment?
❑ No ❑ Yes Explain ______________________________________

5. Generally, how have you felt about your previous dental appointments?
❑ Very anxious and afraid ❑ Don't care one way or the other
❑ Somewhat anxious and afraid ❑ Look forward to it

6. How much do you agree or disagree with this statement: Oral health affects general health.
❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

7. Are you experiencing any of the following symptoms? *(Please check all that apply)*
❑ Sensitive teeth ❑ Sore Jaw ❑ Toothache ❑ Sore gums ❑ Bad breath
❑ Bleeding gums ❑ Difficulty chewing ❑ Filling fell out ❑ Dry mouth ❑ Abscess
❑ Burning sensation ❑ Recession ❑ Yellowing teeth ❑ Sinus problems
❑ Swelling inside mouth ❑ Tartar buildup ❑ Difficulty swallowing

8. Do you clench or grind your teeth in the daytime or at night?
❑ Yes ❑ No
If yes, do you wear a bite guard? ______________ For how long? ______________

9. In the past two years, have you been concerned about your breath or the appearance of your teeth or face?
(If yes, please check all that apply)
❑ Yellowing/graying teeth ❑ Spacing between teeth ❑ Bad breath ❑ Gums
❑ Crowded, crooked teeth ❑ Facial Profile ❑ Stains

10. Have you experienced any injuries to your teeth, face and jaw?
❑ No ❑ Yes Explain ______________________________________

11. Have you experienced any of the following?
❑ Root planing ❑ Gum surgery ❑ Severe pain of face/head
❑ Tooth extractions ❑ Orthodontics/braces ❑ Bad reaction to a local anesthetic
❑ Dental implants ❑ Head and neck radiation therapy ❑ Prolonged bleeding after dental treatment
❑ Root canals ❑ Jaw surgery ❑ Other

Patient Dental History (cont.)

Part II. Oral Self-Care

1. Check the following you regularly use at home:
   - ❑ Soft toothbrush
   - ❑ Hard toothbrush
   - ❑ Medium toothbrush
   - ❑ Oral irrigator
   - ❑ Denture adhesive
   - ❑ Denture cleaner
   - ❑ Dental floss
   - ❑ Special brush
   - ❑ Fluoride toothpaste
   - ❑ Rubber tip
   - ❑ Powered interdental cleaner
   - ❑ Power brush
   - ❑ Floss threader
   - ❑ Toothpick
   - ❑ Mouth rinse
   - ❑ Whitening products
   - ❑ Fluoride rinse or gel
   - ❑ Fluoridated drops/tablets
   - ❑ Fluoridated water
   - ❑ Fluoridated water at day care
   - ❑ Bottled water
   - ❑ Other ____________________

2. Check the type of toothpaste you use:
   - ❑ Fluoride
   - ❑ Sensitivity protection
   - ❑ Tartar control
   - ❑ Baking soda
   - ❑ Gum benefit
   - ❑ Peroxide
   - ❑ Multiple benefit

3. Estimate how long it takes you to clean your teeth and gums each time:
   Please indicate your best and most reliable estimate.

   Brushing ______________ (Time) Flossing ______________ (Time)

4. About how many times each day/week do you brush and floss?

   Brush about __________ times per day OR __________ times per week

   Floss about __________ times per day OR __________ times per week

5. Do you find it difficult to maintain an oral hygiene schedule due to your job or other reasons?
   ❑ Yes ❑ No

6. Do any conditions make it difficult for you to adequately clean your teeth? *(If yes, please check all that apply)*
   - ❑ Hold a toothbrush
   - ❑ Use dental floss
   - ❑ Brush/floss for any length of time
   - ❑ Poor vision

7. Do you perform a monthly self-exam for oral cancer? ❑ Yes ❑ No

Part III. Between-Meal Snacks

Please check which sweets and starches you eat between meals frequently

Food	Frequency	Food	Frequency
❑ Breath mints	______	❑ Canned/bottled beverages	______
❑ Cough drops	______	❑ Sugared liquids	______
❑ Chewing gum	______	❑ Chips	______
❑ Dried fruits	______	❑ Crackers	______
❑ Cookies	______	❑ Others	______