CIRELLI FAMILY DENTISTRY

YOUR DENTAL HISTORY

It is important that we know about your dental history. These facts have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone. Thank you for your cooperation in completing this questionnaire.

Are you having any discomfort in the mouth at the time? Yes ☐ No ☐

Do you have any swelling or lumps in your mouth that you are aware of? Yes ☐ No ☐

How long has it been since you have last been to a dentist? _____

Do you experience unpleasant taste in the mouth or bad breath? Yes ☐ No ☐

What was done at that time (last dental appointment)?_____

Did you have dental X-rays? Yes ☐ No ☐

Have you lost any teeth? Yes ☐ No ☐

Have you ever had any dental extractions or complications from extractions? Yes ☐ No ☐

Have you had any of the following: Denture ☐ Fixed Bridge ☐

Removable Partial Denture ☐ Implants ☐ Other ☐

Are your teeth sensitive to: Heat ☐ Cold ☐ Sweets ☐ Sour ☐

Have you ever had braces? Yes ☐ No ☐

How long do you use a tooth brush before replacing it? _____

Do you use dental floss? Yes ☐ No ☐

Do you have bleeding gums? Yes ☐ No ☐

Have you ever had any type of gum surgery? Yes ☐ No ☐

Does food wedge between your teeth? Yes ☐ No ☐

Do you grind or clench your teeth? Yes ☐ No ☐

Do you have pain around your ears? Yes ☐ No ☐

Do you hear popping, clicking or other noises when you chew? Yes ☐ No ☐

Does your jaw lock open or closed? Yes ☐ No ☐