BRAFMAN
FAMILY DENTISTRY

KEVIN H. BRAFMAN D.D.S. WENDY W. BRAFMAN D.D.S.

DENTAL HISTORY

Name_____ Birthdate_____

What is the reason for your visit today?_____

_____

Date of Last Dental Visit_____ Last Dental Cleaning_____

Last Full Mouth Series Of Radiographs_____

What was done at your last dental visit? _____

_____

Previous Dentist's Name_____

Address _____ State_____

Zip_____ Telephone:_____

How often do you have dental examinations?_____

How often do you brush your teeth?_____ How often do you floss?_____

What other dental aids do you use? (water pick, electric toothbrush, etc.) _____

Do you have any dental problems now? ___ Yes ___ No

If yes, please describe: _____

Are your teeth sensitive to:

Hot or cold? Yes No
Sweets? Yes No
Biting or chewing? Yes No
Have you noticed any mouth odors or bad tastes? Yes No
Do you get cold sores, blisters, other oral lesions? Yes No

Do your gums bleed or hurt? Yes No
Have your parents had gum disease/tooth loss? Yes No
Have you noticed any loose teeth or change in bite? Yes No

Do you:

Clench or grind your teeth while awake or asleep? Yes No
Bite your lips or cheek regularly? Yes No
Hold foreign objects with your teeth (pencils, pipes, pins, nails, fingernails)? Yes No
Mouth breathe while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No
Snore or have any other sleeping disorders? Yes No
Smoke, chew tobacco, use other tobacco products? Yes No

Have you ever had:

Orthodontic treatment? Yes No
Oral surgery? Yes No
Periodontal treatment? Yes No
Your teeth ground or bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to your mouth or head? Yes No
If so, please describe, including cause:

Have you ever experienced:

Clicking or popping of the jaw? Yes No
Pain (joint, ear, side of face)? Yes No
Difficulty in opening or closing the mouth? Yes No
Difficulty in chewing on either side of the mouth? Yes No
Headaches, neck aches, or shoulder aches? Yes No
Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No
Would you like to keep all your teeth your whole life? Yes No

(For child patients only) Does your child:

Suck his/her thumb or pacifier? Yes No
Take fluoride supplements? Yes No
Go to bed at night with food or drinks? Yes No

Do you use alcoholic beverages? Yes No How much?_____ How long?_____

How would you rate your smile? Worst 1 2 3 4 5 6 7 8 9 10 Best

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe: