Cordido Dental Pros

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DENTAL HISTORY

Patient Name: _____ DOB: ____/____/_____
Last First Middle

What brings you to the clinic today? _____

Do you have any dental pain? _____

Are you receiving routine dental care? __ Yes __ No

Date of last Dental Visit? _____ Reason _____ Last Dental X-rays _____

Are your teeth sensitive to hot, cold, sweet, pressure? _____

Do you have any swelling(s) in your mouth? _____

Are your teeth loose or shifting? _____

Have you felt any change of your bite? _____

Are you satisfied with the appearance of your teeth? What would you like to change? _____
_____

PAST DENTAL TREATMENT:

- ☐ Orthodontics (braces) _____
- ☐ Oral Surgery (extractions, etc) _____
- ☐ Periodontics (gum treatment) _____
- ☐ Endodontics (Root canal) _____
- ☐ Restorations (Fillings) _____
- ☐ Crowns and Bridges _____
- ☐ Partial Dentures _____
- ☐ Full Dentures _____
- ☐ Dental implants _____

Dentures and/or partial dentures:

How long worn? _____ Age of present denture? _____ How many past dentures? _____

Any current problem? _____ Reason for Replacement _____

Have you ever had problem/complications with past dental care? Please explain _____
_____

Where did you grow up? _____What was the source of your drinking water? _____

ORAL HYGIENE

Type of toothbrush that you use: __ Hard __ Med __ Soft __ Extra Soft __Electric. Brushing #times/day _____

Flossing # times/day: _____ Toothpaste type: __Fluoride __ Whitening ___Tartar Control __ Other _____

Other fluoride

____ Rinse (OTC) ____ Prescription __ gel ___ Toothpaste __ tablets ____ Other

Mouth Rinse # times/day _____ Brand ? _____

Other Oral self-care _____

Salivary Function

□ Does your saliva feels thick or ropey? □ Does your mouth feels dry? □ Do you have excess saliva?

□ Do you have difficulty chewing food? □ Do you have difficulty speaking?

Is there any other dental concern that has not been discussed? _____
_____

Please indicate if you experience or have experience any of these symptoms. Use the scale to measure the severity:
0 – No occurrence 1 – Occurs Rarely 2 – Occurs 2-4 times per week 3 – Occurs 5-7 times per week

__ Snoring
__ Interrupted snoring where breathing stops
__ Labored, difficult or loud breathing at night
__ Gasping for air when sleeping
__ Mouth breathing while Awake
__ Mouth breathing while sleeping
__ Restless Sleep
__ Grinds teeth while sleeping
__ Talks in sleep
__ Excessive sweating while sleeping
__ Wakes up at night
__Feels Sleepy and/or irritable during the day
__ Headaches

__ Frequent throat infections
__ Seasonal Allergies
__ Short attention span
__ Difficulty listening/ often interrupt
__ Hyperactive
__ ADD/ADHD
__ Sensory issues
__ Avoidance behavior toward food or certain types of food
__ Speech issues

Only Children and Adolescents
__ Wets the bed (currently)
__ History of bed Wetting
__ Ear infections or history of ear infections
__Struggles in math at school

__Struggles in reading at school
__ Speech issues
__ Difficult to understand speech
__ Difficult to understand over the phone
__ Nasal Speech
__ Hoarseness
__ Other have difficulty understanding speech
__ Gets frustrated when people can't understand
__ Speech sounds abnormal
__ Sometimes omits consonants
__ Uses M,N,NG instead of P,V,S,Z sounds
__ Drinking or solids get into nasal area when eating or drinking

SIGNATURE OF PATIENT: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand that it is very important to report any changes or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

Signature: _____ Date: _____

If other than the patient, indicate relationship: parent or legal guardian _____