



Anna M. Munné, D.D.S., P.A.

Periodontics • Implants

Diplomat of the American Academy of Periodontology

PATIENT DENTAL HISTORY

Date _____ Patient Name _____ D/O/B _____

Referring Dentist/ Physician/ Relative _____

General Dentist _____ How long? _____

Primary reason for visit _____

Last cleaning _____ How often? _____ By whom? _____

Last periodontal deep scaling _____ By Whom? _____

Periodontal disease diagnosed? When? _____ By whom? _____

Periodontal surgery? Where? _____ When? _____

By whom? _____

Dental implants? Where? _____ When? _____

By whom? _____

Gum grafts? Where? _____ When? _____

By whom? _____

Teeth extracted? Where? _____ When? _____

By whom? _____

Orthodontic treatment? Yes No How long? _____ By whom? _____

Do you experience: _____ gingival pain _____ recession _____ swelling
_____ Bad breath _____ ulcerations _____ abscesses _____ bleeding

Do you experience sensitivity to: _____ pressure _____ hot _____ cold
_____ Brushing _____ sweets _____ biting

Do you have any loose teeth? _____ Where? _____

Are you aware of any grinding or clenching? _____

Do you wear a mouthguard? _____ Hard Soft

Do your jaws: _____ click? _____ pop? Are they painful? Yes No

Do you have earaches? Yes No

TMJ treatment? _____ By whom? _____

What do you think about dentures? _____

Oral Health Care

How many times a day do you brush? 1 2 3 4

Times during the day? AM Noon Bedtime

Type of toothbrush Handheld Electric

How many times a day do you floss? 0 1 2 3

Times during the day? AM Noon Bedtime

Fluorides _____ Mouthwash _____ Other _____

I HEREBY AFFIRM THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE

DATE

PRINT NAME

PARENT/GUARDIAN