

*DR. ANNA MUNNE, DDS, PA*  
**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?** Y N 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**

X \_\_\_\_\_

\_\_\_\_\_

X \_\_\_\_\_

\_\_\_\_\_

X \_\_\_\_\_

\_\_\_\_\_