Glenwood Dental
General & Cosmetic Dentistry

Dental History

Reason for today's visit: _____

When was your last dental visit: _____

How often do you brush your teeth: _____ What texture toothbrush do you use: Soft Medium Hard

Is there anything about your smile that you do not like: _____

What would you like to accomplish in your dental treatment: _____

Please circle an answer for **each question listed below:*

Do you have any old fillings or treatment that you are unhappy with: YES NO

Do your gums bleed while brushing: YES NO

Do your gums bleed when flossing: YES NO

Are your teeth sensitive to hot, cold, sweet or sour foods or liquids: YES NO

Have you noticed any loosening of your teeth: YES NO

Does food tend to become caught between your teeth: YES NO

Do you have any sores or lumps in or near your mouth: YES NO

Have you ever experienced any of the following problems in your jaw:

- Clicking YES NO
- Pain (joint, ear, side of face) YES NO
- Difficulty opening/closing YES NO

Would you like your teeth to be whiter: YES NO

Do you have frequent headaches: YES NO

Do you clench or grind your teeth: YES NO

Do you bite your lips or cheeks frequently: YES NO

Have you ever had:

- Orthodontic treatment (Braces): YES NO
- Oral Surgery: YES NO
- Your teeth reshaped or bite adjusted: YES NO
- Worn a night guard, bite plate or other appliance: YES NO

Are you satisfied with the appearance of your teeth and smile: YES NO

Have you ever had an upsetting experience in a dental office: YES NO

Is there anything about having dental treatment done that concerns you: YES NO _____

Medical History

Do you consider yourself to be in good health: YES NO

Have there been any changes in your general health within the past year: YES NO _____

When was your last physical exam: _____

Physician's name: _____

Address: _____

Telephone: _____

Are you currently under the care of a physician: YES NO

Have you ever been hospitalized for any surgical operation or serious illness: YES NO
If yes, please explain: _____

Are you currently taking any medication(s) including nonprescription medicine(s): YES NO
If yes, list here: _____

Have you had recent weight loss: YES NO

Are you currently taking diet pills or herbs: YES NO
If yes, list here: _____

Have you or are you currently taking osteoporosis medication such as Fosamax®: YES NO
If yes, list here: _____

Have you had any abnormal bleeding: YES NO

Do you bruise easily: YES NO

Have you ever required a blood transfusion: YES NO

Do you use tobacco: YES NO

Do you use alcohol: YES NO

Do you use cocaine or other drugs: YES NO

Are you wearing contact lenses: YES NO

Do you have any disease, condition, or problem not listed above that you believe I should know about: YES NO
If yes, please explain: _____

Are you allergic to or have you had reactions to:

- Local anesthetics: YES NO
- Penicillin: YES NO
- Sulfa Drugs: YES NO
- Barbiturates, Sedatives or Sleeping Pills: YES NO
- Aspirin: YES NO
- Iodine: YES NO
- Latex: YES NO
- Other Antibiotics: _____
- Other Allergies: _____

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