

# FRED KEYSER DDS, PA

COMPREHENSIVE, RESTORATIVE, COSMETIC DENTISTRY

## Dental History

Patient Name: \_\_\_\_\_ Patient Acct. No.: \_\_\_\_\_  
Medical Alert: \_\_\_\_\_

*Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.*

**What is the reason for your visit today?** \_\_\_\_\_  
\_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Last dental cleaning: \_\_\_\_\_ Last full mouth x-rays: \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_  
\_\_\_\_\_

Previous Dentist's Name: \_\_\_\_\_ Telephone \_\_\_\_\_  
Address (Street, City, State, Zip) \_\_\_\_\_

### 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? (Interplak, toothpick, etc.) \_\_\_\_\_

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

If yes, please describe: \_\_\_\_\_

### Are any of 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 frequently get cold sores, blisters or any other oral lesions?  Yes  No

### Do your gums bleed or hurt?

- Have your parents experienced gum disease or tooth loss?  Yes  No
- Have you noticed any loose teeth or change in your bite?  Yes  No
- Does food tend to become caught in between your teeth?  Yes  No

If yes, where: \_\_\_\_\_

### Do you:

- Clench or grind your teeth while awake or asleep?  Yes  No
- Bite your lips or cheeks regularly?  Yes  No
- Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)?  Yes  No
- Mouth breathe while awake or asleep?  Yes  No
- Have tired jaws, especially in the morning?  Yes  No
- Smoke/chew tobacco?  Yes  No

### Have you ever had:

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

### Have you 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
- Headache, neck aches or shoulder aches?  Yes  No
- Sore muscles (neck, shoulders)?  Yes  No

### Are you satisfied with your teeth's appearance?

- Would you like to keep all of your teeth all your life?  Yes  No
  - Do you feel nervous about having dental treatment?  Yes  No
- If so, what is you biggest concern? \_\_\_\_\_  
\_\_\_\_\_

- Have you ever had an upsetting dental experience?  Yes  No
- If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

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