Parkway Periodontal Group

ORAL HISTORY

Answers to all questions are for office use only and are strictly confidential.

What is your chief dental concern at this moment? _____
Why were you referred to our office? _____
Who is your regular dentist? _____ How long have you been a patient of your current dentist? _____
Date of last visit/exam: _____ Did you have x-rays at your last dental visit? □ Yes □ No
Has your dental care been:
□ regular (yearly) □ intermittent (when necessary) □ infrequent (when in pain)
Approximate date when your teeth were last cleaned: _____
How often do you have your teeth cleaned by a dentist or hygienist? _____
Have you ever had any previous gum/periodontal treatment in the past? □ Yes □ No
If so, when: _____ □ with periodontist □ with general dentist
How often do you brush your teeth per day? _____
Do you use an □ electric or a □ manual toothbrush? Type of bristle: □ hard, □ medium, or □ soft
Do you use mouthwash? □ Yes □ No Type/Brand: _____
What additional aids do you use to clean your teeth and gums? □ floss □ proxy brush □ rubber tip □ other_____
Do you drink sugared beverages regularly? □ Yes □ No If yes, how much: _____
Have you ever had endodontic (root canal) therapy? □ Yes □ No If yes, when: _____
Have you ever had TMJ (joint) therapy? □ Yes □ No If yes, when: _____
Have you ever had orthodontic (braces) therapy? □ Yes □ No If yes, when: _____
Have your third molars (wisdom teeth) been removed? □ Yes □ No
Have you ever had an injury or pain to your face, neck, or jaws? □ Yes □ No
Do you often find yourself clenching and/or grinding your teeth? □ Yes □ No
Have you had an abnormal reaction to dental anesthetic? □ Yes □ No If yes, describe: _____
Is there sensitivity in your teeth? □ Yes □ No
If yes, to: □ hot □ cold □ sweets □ tooth brushing □ pressure □ biting
Do you use candy or mints routinely? □ Yes □ No
Have you ever experienced a problem with a dry mouth or a decrease in saliva? □ Yes □ No
Have you ever experienced any of the following:
□ bleeding gums □ swelling □ pain or soreness in gums □ receding gums
□ pus around the teeth □ loose teeth □ spaces between teeth □ drifting of teeth
□ foul odor □ food packing □ high or rough filling □ bad breath or bad taste
Do you prefer sedation for your periodontal surgical therapy? □ Yes □ No
□ intravenous conscious sedation □ oral sedation □ nitrous
Other comments: _____

I understand that the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information.

Date: _____
Patient Name (please print): _____
Patient/Guardian Signature: _____

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