DR. DALESANDRO & ASSOCIATES
FAMILY OWNED SINCE 1978

DENTAL HISTORY

NAME (PLEASE PRINT): _____ DATE: _____
LAST FIRST MI

CHIEF COMPLAINT OR PURPOSE OF THIS APPOINTMENT: _____

DATE OF LAST VISIT: _____ PURPOSE: _____

DATE OF LAST DENTAL CLEANING: _____

DATE OF LAST FULL MOUTH OF X-RAYS: _____

HAVE YOU EVER HAD SCALING OR ROOT PLANING, AKA A "DEEP CLEANING"? YES ____ NO ____ IF YES, DATE: _____

NAME OF PREVIOUS DENTIST: _____ CITY: _____

		YES	NO
ARE YOUR TEETH SENSITIVE TO:	COLD?		
	HEAT?		
	SWEETS?		
	PRESSURE?		
WHEN CHEWING GUM, DO YOU AVOID ONE SIDE?			
IF YES, WHICH SIDE? _____			
DO YOUR GUMS BLEED WHEN BRUSHING?			
DO YOU USE DENTAL FLOSS?			
IF YES, HOW OFTEN?			
DOES THE FLOSS CATCH OR TEAR?			
IF YES, WHERE? _____			
HAVE YOU EVER BEEN INSTRUCTED ABOUT PROPER HOME CARE?			
DOES FOOD CATCH BETWEEN YOUR TEETH?			
IF YES, WHERE? _____			
DO YOU HAVE AN UNPLEASANT ODOR OR TASTE IN YOUR MOUTH?			
DO YOU GRIND OR CLENCH YOUR TEETH?			
DO ANY OF YOUR TEETH FEEL LOOSE?			
IF YES, WHICH? _____			
DO YOU EVER AWAKEN WITH PAIN NEAR YOUR EARS OR JAW MUSCLES?			
DO YOU HEAR CLICKING OR POPPING WHEN YOU CHEW?			
HAVE YOU EVER HAD ORTHODONTIC TREATMENT?			
HAVE YOU EVER BEEN TREATED FOR A BAD BITE?			