Stoneham Dental Care
112 Main Street
Stoneham, MA 02148
781-438-1995

DENTAL HISTORY

Patient's Name: _____

Last Dental Visit: _____

Last Dental Cleaning: _____

Previous Dentist's Name: _____

Do you have any problems now? Yes No

Are any of your teeth sensitive:

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 lesions? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Do you?

Clench or grind your teeth while awake or asleep? 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 bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

Do your gums bleed or hurt? Yes No
If so please describe_____
_____

Have you experienced?

Clicking or popping of the jaw? Yes No

Pain?
(Joint, ear, side of face) Yes No

Difficulty opening or closing your mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neck aches, or shoulder aches? Yes No

Sore muscles?
(neck or shoulders) Yes No

Do you feel nervous about having dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know about? Yes No
If yes, please describe

_____
_____
_____