Ponce de Leon Family Dentistry

4 St. Johns Medical Park Drive
St. Augustine, FL 32086
Phone: (904) 797-9009 Fax: (904) 797-9057

DENTAL HISTORY

Thank you for selecting our dental healthcare team. Please respond to the following dental history questionnaire, designed to open a discussion of your dental concerns. Should you need assistance, we are glad to help.

Your current dental health is: Good Fair Poor

Describe your current dental problem(s) or concern(s):
_____

When was your last dental hygiene appointment?_____

What dental aids do you use? Electric toothbrush toothpicks proxibrushes

Yes	No	Have you ever had root planing (deep cleaning) done?
Yes	No	Have you been experiencing pain or discomfort related to your teeth, gums or jaw joints?
Yes	No	Do you have a bite plate or mouth guard?
Yes	No	Have you had clicking, popping or pain in your jaw joint or muscles?
Yes	No	Have you noticed any mouth odors (halitosis) or bad tastes?
Yes	No	Are your gums red, swollen, glossy or tender?
Yes	No	Do your gums bleed or hurt?
Yes	No	Have your parents ever experienced gum disease or tooth loss?
Yes	No	Do you frequently experience cold sores, blisters or any other oral lesions?
Yes	No	Have you noticed any loose teeth?
Yes	No	Have you noticed a change in your bite?
Yes	No	Do you clench or grind your teeth while awake or asleep?
Yes	No	Have you experienced a serious injury to the mouth or head?
Yes	No	Would you like to keep your natural teeth for as long as you live?
Yes	No	Do you get frustrated that you need work done every time you go to the dentist?
Yes	No	Are you satisfied with your teeth's appearance?
Yes	No	Would you like to have whiter teeth?
Yes	No	Would you like your teeth to be straighter?
Yes	No	Do you have metal or discolored fillings that you are unhappy with?
Yes	No	Do you have crowns or bridges that are unattractive or unnatural-looking?
Yes	No	Do you sometimes feel uncomfortable with the appearance of your smile?
Yes	No	Do you have unattractive spaces between your teeth?
Yes	No	Do you experience headaches, neckaches or shoulder aches?
Yes	No	Do you have difficulty opening or closing your mouth?
Yes	No	Have you ever had periodontal treatment?
Yes	No	Are you apprehensive about dental treatment? If so, what are concerns?

_____ _____
Signature Date