PATIENT DENTAL HISTORY
KEVIN T. NELSON, D.D.S., LTD.

Patient Name: _____

1. Do you have gums bleed while brushing or flossing?.....Yes__ No__
2. Are your teeth sensitive to hot or cold liquids or foods?.....Yes__ No__
3. Are your teeth sensitive to sweet or sour liquids or foods? ..... Yes__ No__
4. Do you feel pain with any of your teeth? .....Yes__ No__
5. Do you have any sores or lumps in or near your mouth? .....Yes__ No__
6. Have you had any head, neck, or jaw injuries? ..... Yes__ No__
7. Have you ever experienced any of the following problems in your jaw?
   a. Clicking?..... .....Yes__ No__
   b. Pain (joint, ear, side of face)?..... Yes__ No__
   c. Difficulty in opening or closing?..... Yes__ No__
   d. Difficulty in chewing?..... Yes__ No__
8. Do you have frequent headaches?.....Yes__ No__
9. Do you clench or grind your teeth?.....Yes__ No__
10. Do you bite your lips or cheeks frequently?.....Yes__ No__
11. Have you ever had any difficult extractions in the past?.....Yes__ No__
12. Have you had any orthodontic work?.....Yes__ No__
13. Have you ever had prolonged bleeding following extractions?.....Yes__ No__
14. Have you ever had instructions on the correct method of brushing your teeth?...Yes__ No__
15. Have you ever had instructions on the care of your gums?..... Yes__ No__

What is the reason for your visit today?

_____

_____

Date of last dental visit:_____ What was done for you at that visit?

_____

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Do you have any dental problems now? Yes _____ No_____

If yes, please describe:_____

Are you satisfied with teeth's appearance? Yes _____ No _____

What would you change about your smile?

_____

Do you brush, floss or use any other dental aids?

_____

Is there anything else about having dental treatment that you would like us to know? _____

_____

Do you have any problems sleeping or been told you have Sleep Apnea? Yes?___ No ___

If yes, please explain:

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature _____ Date _____