DENTAL HISTORY

Name:____ **Date:**_________________________

1. Dental complaint at the moment: ____

   ____

2. Has your dental care been?

   Regular (recalled regularly by your dentist)

   Irregular (when you felt it is necessary to seek dental care)

   Infrequent (dental care when you were in pain)

3. Approximate date when your teeth were last cleaned: ______________
4. Were you ever treated for a painful mouth infection? Yes No
5. Have you ever had Trench Mouth? Yes No
6. Are any of your teeth loose? Yes No
7. Have you ever been treated for periodontal disease? Yes No

   If so, by whom and when? __________________________

8. Have you ever had your teeth straightened? Yes No
9. Do your jaws ever feel tired? Yes No
10. Do you ever have pain in or near your ear? Yes No
11. Do you "grind" your teeth during the day or night? Yes No
12. Does food catch between your teeth? Yes No

    If so, where? ___________________________________

13. Does heat, cold or sweets cause pain in your mouth? Yes No

    If so, where? ___________________________________

14. When do you brush your teeth? _____________________________
15. Do you use anything other than a tooth brush to care for your teeth and gums? Yes No

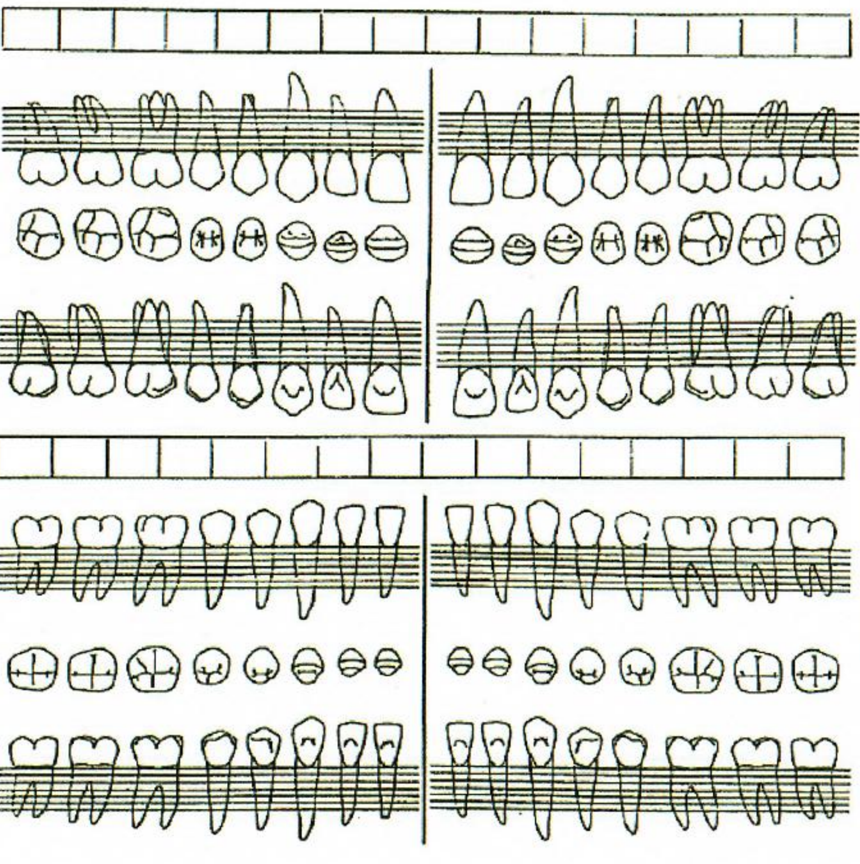
    If so, what? ____________________________________

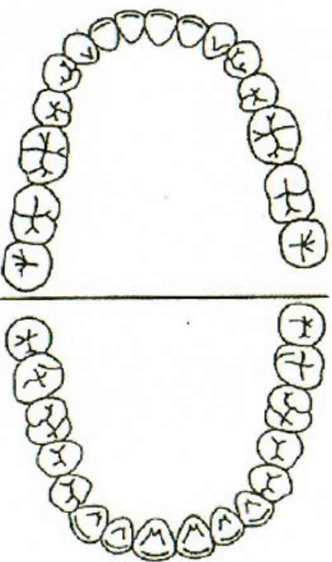
16. Do your gums bleed while you brush your teeth? Yes No
17. Do you notice a bad taste in your mouth? Yes No
18. Have you ever had a gum abscess (gum boil)? Yes No

PLEASE SIGN HERE:____

SEMINARIAN APPLICANT

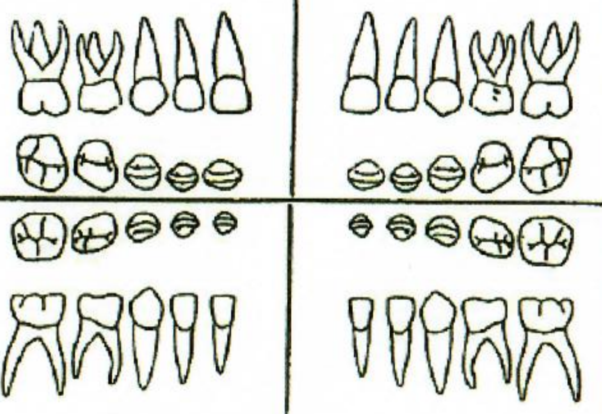
Name: ______________________________





Special Restorations:

____



Occlusion ________________________

Prematurities ________________________

Right Lateral ________________________

Left Lateral ________________________

Orthodontics ________________________

Tongue Thrusting ________________________

Mouth Breathing ________________________

Summary of Treatment:

____

L	R	#				

Pain opening or closing mouth: ________________

Clench or grind teeth: ________________

Sore areas in mouth or gums: ________________

Food Impaction: ________________

Sensitive teeth: ________________

Complications following extraction: ________________

Gum infections: ________ Frequency: ________

Previous gum treatments: ________________

Bleeding gums: ________ Frequency: ________

Tooth brushing: ________________

Remarks: ________________

____

Dentist: ________________

Address: ________________

Phone: ________________