Howard Family Dental
Fact Sheet and Dental History

Patient: ____________________

Employment: ____________________

Hobbies/Interests in spare time: ____________________

Children/Number and ages: ____________________

Grandchildren/Number and ages: ____________________

Birthplace: ____________________

How long married ____________________

Other items of interests: ____________________

Question		
Are you having **PROBLEMS** now?	○ Yes	○ No
What area of your mouth is causing a problem?	____________________	
Are you in pain?	○ Yes	○ No
Do you wear **DENTURES**? (Partials or Full)	○ Yes	○ No
Are you unhappy with your dentures?	○ Yes	○ No
Have you any **DEEP CLEANINGS (GUM)** treatments?	○ Yes	○ No
Do your gums **BLEED**, or feel **TENDER**, or **IRRITATED**?	○ Yes	○ No
Are your teeth **SENSITIV**E to hot, cold, sweets, or	○ Yes	○ No
Do you have problems with teeth/fillings **BREAKING**?	○ Yes	○ No
Are you aware of **GRINDING** or **CLENCHING** your	○ Yes	○ No
Do you have **HEADACHES**, **EARACHES**, or **NECK**	○ Yes	○ No
Do you have **LOOSE**, **TIPPED** or **SHIFTING** teeth?	○ Yes	○ No
Have you worn **BRACES** on your teeth?	○ Yes	○ No
Are you interested in **ORTHO** OR **INVISALIGN**?	○ Yes	○ No
Do you have **DISCOLORED** teeth that bother you?	○ Yes	○ No
Are you happy with your **SMILE**?	○ Yes	○ No
Do you wear any type of **SLEEP APPLIANCE**?	○ Yes	○ No
Do you **SNORE**?	○ Yes	○ No