Dr. Bruce M. Crawford
Implant Dentistry & Laser Periodontics

Dental History

1. Nature of your dental problem. _____
2. Are you having pain or discomfort at this time? Where? _____ Y N
3. Are any of your teeth sensitive to hot, cold, sweet or sour? Where? _____ Y N
4. Do you have sores in or around your mouth? Where? _____ Y N
5. Do your gums bleed? If so, When? _____ Y N
6. Have you ever had periodontal treatment? If yes, When? _____ Y N
   What? _____ Where? _____
7. Do you have any breath odor or unpleasant taste? _____ Y N
8. Do you have loose teeth? If yes where? _____ Y N
9. Do you have any popping, grinding, locking or pain in either jaw joint? Y N
10. Has your dental care been regular? Y N
11. How long ago was your last dental cleaning? ❒ 3 mos. ❒ 4 mos. ❒ 6 mos. Other _____
12. How often do you have your teeth cleaned? ❒ 3 mos. ❒ 4 mos. ❒ 6 mos. Other _____
13. When was the last time you had dental x-rays taken? ❒ 6 mos. ❒ 1 yr. ❒ 5 yrs. Other _____
14. How many times a day do you brush your teeth? ❒ once ❒ twice ❒ three Other _____
15. Do you floss? Y N How often? ❒ daily ❒ 2-3x week ❒ weekly Other _____
16. Do you have removable dental appliances/partial/dentures? _____ Y N
17. Have you ever had orthodontic treatment (braces)? If yes, when? _____ Y N
18. Do you smoke? Y N If yes, how much? _____
19. Have you smoked in the past? Y N Quit date _____
20. Do you chew tobacco, use snuff or smoke cigars? Y N How often? _____
21. Have you ever had serious problems with dental treatment? _____ Y N
    If yes, please explain _____
    _____
22. Have you had any unpleasant dental experiences or is there anything about dentistry you strongly dislike? _____
    _____

I certify that the above information is complete and accurate.

_____ _____

Patient Name (Parent/Guardian if minor) *Date*