JOSEPH C. STYGER, D.D.S., INC. — Dental History

Patient Name

Welcome! So that we may provide you with the best possible care
Please complete both sides of this medical/dental history form.
All information is completely confidential.

What is the reason for your visit today?_____
_____

Date of Last Dental Visit_____ Last Dental Cleaning_____ Last Full Mouth X-ray_____
What was done at your last dental visit?_____
_____
Previous Dentist's Name_____
Address_____City_____Zip_____
Telephone_____

How often do you have dental examinations?_____
How often do you brush your teeth?_____ How often do you floss_____
Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc)_____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:			**Do you:**		
Hot or cold?	Yes	No	Clench or grind you teeth while awake or asleep?	Yes	No
Sweets?	Yes	No	Bite your lips or cheeks regularly?	Yes	No
Biting or Chewing?	Yes	No	Hold foreign objects with your teeth? (pencils, pins, etc)	Yes	No
Have you noticed any mouth odors or bad taste	Yes	No	Mouth breathe while awake or asleep?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions	Yes	No	Have tired jaws, especially in the morning?	Yes	No
Do your gums bleed or hurt?	Yes	No	Snore or have any other sleeping discorders?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No	Smoke/chew tobacco or use other tobacco products?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No	**Have you ever had:**		
Does food tend to become caught in between your teeth? If yes where?_____	Yes	No	Orthodontic treatment?	Yes	No
Have you experienced:			Oral Surgery?	Yes	No
Clicking or popping of the jaw?	Yes	No	Periodontal treatment?	Yes	No
Pain? (joint, ear, side of face)	Yes	No	Your teeth ground or the bite adjusted?	Yes	No
Difficulty in opening or closing the mouth?	Yes	No	A bite plate or mouth guard?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No	A serious injury to the mouth or head? If so please describe, including cause_____	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No	Are you satisfied with your teeth's appearance?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No	Do you feel nervous about having dental treatment?	Yes	No

Have you ever been told to take a pre-medication prior to dental treatment? Yes No
Have you ever had an upsetting dental experience? Yes No
If yes, please describe_____

_____
Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please desbribe_____

_____