



Krishna Neelagiri, DDS

Dental History

Patient Name _____ Medical Alert _____

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

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 you currently using topical fluoride? Yes No

What other dental aids do you use? (Electric Toothbrush, toothpick, etc.) _____

Do you have any dental problems now? Yes No If yes, please describe: _____

Do you feel nervous about having dental treatment? Yes No If yes, please describe: _____

Have you ever had an upsetting dental experience? Yes No If yes, please describe: _____

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

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

Do you or have you had any of the following ? :

- Orthodontic treatment Yes No
- Oral Surgery Yes No
- Periodontal treatment Yes No
- Your teeth ground or the bite adjusted Yes No
- A bite plate or mouth guard Yes No
- Clicking or popping of the jaw Yes No
- Pain? (joint, ear, side of face) Yes No
- Difficulty in opening or dosing the mouth Yes No
- Difficulty in chewing on either side of the mouth Yes No
- Headaches, neck-aches or shoulder aches Yes No
- Sore muscles (neck, shoulders) Yes No
- Dry mouth Yes No
- Gag easily Yes No
- Lip/Tongue piercing Yes No
- Wear full/partial dentures Yes No
- Need to chew on one side of mouth Yes No
- A serious injury to the mouth or head Yes No

Please describe, including cause _____

Are any of your teeth sensitive to ? :

- Hot or cold Yes No
- Sweets Yes No
- Biting or Chewing Yes No
- Have you noticed any mouth odors or bad tastes Yes No
- Do you frequently get cold sores, blisters or any oral lesions Yes No

- Do your gums bleed or hurt Yes No
- Have your parents experienced gum disease or tooth loss Yes No
- Have you noticed any loose teeth or change in your bite Yes No
- Does food tend to become caught in between your teeth Yes No
- If yes, where: _____

Do You ? :

- Clench or grind your teeth while awake or asleep Yes No
- Bite your lips or cheeks regularly Yes No
- Hold foreign objects with your teeth (pencils, pipe, etc.) Yes No
- Mouth breathe while awake or asleep Yes No
- Have tired jaws, especially in the morning Yes No
- Snore or have any other sleeping disorders Yes No
- Smoke/chew tobacco or use other tobacco products Yes No

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