Rochelle E. Hackley DDS LLC, Dental Spa

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DENTAL HISTORY

Thank you for selecting our dental healthcare team. Please respond to the following dental history questionnaire, designed to open a discussion of your dental concerns. Should you need assistance, we are glad to help.

Your current dental health is: Good   Fair   Poor

Describe your current dental problem(s) or concern(s):

____

When was your last dental hygiene appointment?__________________

What dental aids do you use?   Electric toothbrush   toothpicks   proxibrushes

Yes   No   Have you ever had root planing (deep cleaning) done?
Yes   No   Have you been experiencing pain or discomfort related to your teeth, gums or jaw joints?
Yes   No   Do you have a bite plate or mouth guard?
Yes   No   Have you had clicking, popping or pain in your jaw joint or muscles?
Yes   No   Have you noticed any mouth odors (halitosis) or bad tastes?
Yes   No   Are your gums red, swollen, glossy or tender?
Yes   No   Do your gums bleed or hurt?
Yes   No   Have your parents ever experienced gum disease or tooth loss?
Yes   No   Do you frequently experience cold sores, blisters or any other oral lesions?
Yes   No   Have you noticed any loose teeth?
Yes   No   Have you noticed a change in your bite?
Yes   No   Do you clench or grind your teeth while awake or asleep?
Yes   No   Have you experienced a serious injury to the mouth or head?
Yes   No   Would you like to keep your natural teeth for as long as you live?
Yes   No   Do you get frustrated that you need work done every time you go to the dentist?
Yes   No   Are you satisfied with your teeth's appearance?
Yes   No   Would you like to have whiter teeth?
Yes   No   Would you like your teeth to be straighter?
Yes   No   Do you have metal or discolored fillings that you are unhappy with?
Yes   No   Do you have crowns or bridges that are unattractive or unnatural-looking?
Yes   No   Do you sometimes feel uncomfortable with the appearance of your smile?
Yes   No   Do you have unattractive spaces between your teeth?
Yes   No   Do you experience headaches, neckaches or shoulder aches?
Yes   No   Do you have difficulty opening or closing your mouth?
Yes   No   Have you ever had periodontal treatment?
Yes   No   Are you apprehensive about dental treatment? If so, what are concerns?

______________________________ ______________________

Signature   Date