RANDALL L. FOTO, D.D.S.
FAMILY DENTISTRY

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Chart #: _____
FOR OFFICE USE ONLY

DENTAL HISTORY

Name _____ Birthdate _____

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 _____

Address _____ State _____ Zip _____

Telephone _____ Fax _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (waterpik, electric toothbrush, etc.) _____

Are there any areas of your mouth difficult to clean? _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

_____

Are any of your teeth sensitive to:		
Sweets, Hot or cold?	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 other 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
Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Notice excessive wear on your teeth?	Yes	No
Hold foreign objects with your teeth? (Pencils, pipe, pins, nails, fingernails)	Yes	No
Have frequent dry mouth?	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

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Gum treatment?	Yes	No
Your bite adjusted?	Yes	No
A bite plate, splint, or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
Have you ever experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of mouth?	Yes	No
Headaches, neckaches or shoulder aches?		
Sore muscles (neck, shoulders)?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Would you like to improve the appearance of your teeth/smile?	Yes	No
Does your diet include:		
Soft drinks	Yes	No
amount per day_____		
Frequent mints, candies or gum	Yes	No

How would you rate your smile? Worst 1 2 3 4 5 6 7 8 9 10 Best

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe: _____

_____