



YANKEE DENTAL



PHILIP E. GALLAGHER, DDS

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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