Patient Dental Form

Directions: Your teacher will tell you about a patient. With your class, fill out this form with the patient’s information.

1. Do your gums bleed while brushing or flossing? Yes ___ No ___

2. Are your teeth sensitive to hot or cold liquids/foods? Yes ___ No ___

3. Are your teeth sensitive to sweet or sour liquids/foods? Yes ___ No ___

4. Do you feel pain in any of your teeth? Yes ___ No ___

5. Do you have any sores or lumps in or near your mouth? Yes ___ No ___

6. Have you had any head, neck or jaw injuries? Yes ___ No ___

7. Have you ever experienced any of the following problems in your jaw:
   a. Clicking? Yes ___ No ___
   b. Pain (joint, ear, side of face)? Yes ___ No ___
   c. Difficulty in opening or closing? Yes ___ No ___
   d. Difficulty in chewing? Yes ___ No ___

8. Do you have headaches often? Yes ___ No ___

9. Do you clench or grind your teeth? Yes ___ No ___

10. Do you bite your lips or cheeks often? Yes ___ No ___
Patient Dental Form, continued

11. Have you ever had any difficult extractions in the past?  
   Yes  No

12. Have you had any orthodontic treatment?  
   Yes  No

13. Have you ever had prolonged bleeding following extractions?  
   Yes  No

14. Have you ever had instruction on the correct method of brushing your teeth?  
   Yes  No

15. Have you ever had instructions on the care of your gums?  
   Yes  No