Alec J. Temlock, DMD, MS, Inc.
San Francisco Periodontics and Implant Dentistry

Dental History Questionnaire

General Dentist Name: _____ Office Phone: _____

City: _____ State: _____

Last Dental Cleaning: _____ Dental Cleaning Frequency: _____

Oral Hygiene Routine

What is your normal oral hygiene routine at home? (Check all that apply)

☐ Electric Toothbrush ☐ Manual Toothbrush

How many times a day do you brush your teeth? _____

☐ Dental Floss ☐ Mouth Rinses ☐ Floss Threader ☐ StimuDent

☐ Proxy Brushes ☐Water-Pik ☐Rubber Tip ☐Toothpicks

☐ Other (please describe): _____

Adverse Dental Reactions (Check All That Apply):

☐ Dental Anxiety ☐ Dental Material Reaction or Allergy

☐ Difficulty Getting/Staying Anesthetized ☐ Strong Gauge Reflex

☐ Latex Allergy ☐ Lost Consciousness During Procedure

☐ Other (please describe): _____

Previous Periodontal Treatment (Check All That Apply):

☐ Scaling and Root Planing/Deep Cleanings ☐ Extractions

☐ Periodontal Surgery ☐ Bone Graft/Regeneration

☐ Soft Tissue Graft ☐ Implants

Other: _____

Dental History: (Please answer the following questions)

Y N

☐☐ Are you currently experiencing any pain in your mouth, head, or neck?

☐☐ Do you experience any sensitivity in your teeth, gums, or mouth?

☐☐ Do you experience any bleeding when you brush, floss, or use other oral cleaning devices?

☐☐ Are you aware of any dental treatment planned but yet not completed by your general dentist?

☐☐ Have you ever been told you clench or grind your teeth?

☐☐ Has any dentist ever recommended a protective guard for your teeth?

☐☐ Do you have any trouble chewing or swallowing?

☐☐ Have you ever been treated for tempromandibular dysfunction (TMD, TMJ)?

☐☐ Have you ever had a biopsy anywhere in your mouth?

☐☐ Have you previously been told to take antibiotics before dental treatment?

☐☐ Have you experienced any complications following any dental treatment?

☐☐ Have you been treated for any oral abnormality, disease, or pathology not already described?

If yes, please explain: _____

To the best of my knowledge, I answered every question completely and accurately. If I ever experience any changes in my oral health, I will inform Dr. Temlock immediately.

Patient's or Guardian's Signature: _____ Date: _____