Name: ______________________
Date: ______________________

# PLUNKETT & CHAW DENTAL

## MEDICAL HISTORY REVIEW

Last complete physical? ______________________ Who is your physician? ______________________

Are you allergic to any medicines? ______________________

Are you taking any medication? ______________________

Have you ever been in the hospital for treatment, illness or operation? ______________________

Have you ever been treated for heart disease, high blood pressure or cancer? ______________________

Have you ever been tested for metal allergies? ______________________

Are there any other medical problems I need to know about? ______________________

## DENTAL HISTORY REVIEW

Last dental visit? ______________________ What treatment was done? ______________________

Did you have x-rays? ______________________

Did you have regular visits? ______________________ How often? ______________________

Have you lost any teeth? ______________________ Why? ______________________

Are you missing teeth replaced by fixed bridge, removable partial or dentures? ______________________

______________________

If not, have replacements been discussed? ______________________

How often do you brush? ______________________ When? ______________________

Do you floss? ______________________ How often? ______________________ Or other aides? ______________________

Do your gums bleed? ______________________ When? ______________________ Where? ______________________

Does food collect between any of your teeth? ______________________

Do you have an unpleasant taste in any areas? ______________________

Do you eat between meals? ______________________ If so, what? ______________________

Do you chew gum? ______________________ Breath mints? ______________________ sweets? ______________________ fruits? ______________________

Do you drink soft drinks, soda? ______________________ Do you drink coffee with sugar? ______________________ Do you use antacid tablets? ______________________

Are any of your teeth sensitive to sweets, hot or cold? ______________________

Are any of your teeth sensitive to chew or bite on? ______________________

Are you having any discomfort now? ______________________

Are you dissatisfied in any way with your teeth? ______________________

Their function? ______________________ Their appearance? ______________________

Is there anything I should know about your previous dental visits? ______________________

______________________

Are there any other dental problems I should know about? ______________________

______________________

## RADIOGRAPHIC QUESTIONS

Prevalence of fillings ______ few ______ moderate ______ many ______

Any overhanging margins? ______

Any cavities obvious on x-rays? ______

Any periapical infections? ______ List and chart ______

Any bone loss? ______

Any widened periodontal membrane? ______ List ______

Any unerupted teeth? ______

## ORAL EXAM

Blood pressure ______ Pulse ______

General condition of teeth ______ Restored to ______

Any pocket formation (probe pockets) ______

Calculus deposits ______ Slight ______ Moderate ______ Excessive ______

Inflammation present ______Slight ______ Moderate ______ Severe ______

Condition of Saliva ______

General condition of soft tissue? ______ Good ______ Fair ______ Poor ______

Any bone loss? ______ Control? ______ How? ______

Comments? ______

How many cleanings: ______ Fluoride recommended? ______

Any areas of inadequate attached gingiva # ______

Any recession? ______

Erosion? (due to occlusion or toothbrush?) ______

Any unmanageable bacterial traps? (open contacts) ______

Jaw Relationship? ______

______

History of pain in Joints ______ Neck Pain? ______

Temporal Headaches? ______

Any popping or clicking joints? ______

Premature interferences or mobile teeth?______

Location of remaining teeth or any collapsed teeth? ______

Anteriors being bruxed? ______

Ability to open? Normal ______ Limited ______ Minimal ______

Other abnormalities? ______