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 ___