MOORE Family Dental
Michael G. Moore DDS

# Patient Dental History

**NAME:** _____ **DATE:** _____

Is there any change in your general health? □ Yes □ No _____

Any change in medications? □ Yes □ No *(Please list or give us your updated medication list to copy.)*

_____

Do you require antibiotics (pre-medication) before dental treatment? □ Yes □ No

Does anyone in your family have oral cancer? □ Yes □ No _____

Are you happy with your smile? □ Yes □ No _____

Would you like teeth whitening? □ Yes □ No Invisalign® teeth straightening? □ Yes □ No

_____

**Use this checklist as a guide and mark ALL that apply to you today**:

| | | | |
|---|---|---|---|
| □ | anxiety/fearful/feeling scared | □ | loose tooth/teeth |
| □ | bad breath/halitosis | □ | lump |
| □ | bleeding in your mouth | □ | receding gums |
| □ | blisters/sores/lesions | □ | sensitivity (i.e. hot/cold) |
| □ | coating on the tongue | □ | sinus pain |
| □ | dry mouth/sticky feeling in mouth | □ | soreness/tenderness |
| □ | infection/pus | □ | swelling/inflammation |
| □ | injury/trauma | □ | taste/change in or loss of |
| □ | jaw joint pain/popping/pressure | □ | white area |
| □ | | □ | |
| □ | | □ | |
| □ | | □ | asymptomatic (no symptoms) |

_____

_____

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