Amanda Donnelly D.M.D.
742 Graham Road Suite A. Cuyahoga Falls, OH 44221

Dental Health History Information

Name_____

Date of last dental visit _____

Date of last dental cleaning _____

Please answer the following questions:	YES	NO
Do you have a bad taste or odor in your mouth?	( )	( )
Do you have any bumps or sores in your mouth?	( )	( )
Do you have any pain in your mouth?	( )	( )
Is any part of your mouth sensitive to pressure?	( )	( )
Are any of your teeth sensitive to hot, cold or sweets?	( )	( )
Have you ever been told you have gum disease?	( )	( )
Have you ever had gum surgery?	( )	( )
Do you have a family history of gum disease? (parents)	( )	( )
Do your gums bleed when you brush or floss?	( )	( )
Have you had any difficult extractions in the past?	( )	( )
Have you ever had prolonged bleeding after extraction?	( )	( )
Have you been diagnosed/treated with TMJ disorder?	( )	( )
Do you clench or grind your teeth?	( )	( )
Do you have any popping or clicking in your jaw?	( )	( )
Do you have pain in your jaw or near your ear?	( )	( )
Have you had an allergic reaction to dental anesthesia?	( )	( )
Have you had orthodontics/orthodontics consult?	( )	( )
Do you ever experience dry mouth?	( )	( )
Have you ever been given instructions on how to brush and floss your teeth?	( )	( )
How many times a day do you brush your teeth?	_____	
How many times a week do you floss your teeth?	_____	

Do you have any specific dental problems you would like to discuss with Dr. Donnelly? _____

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