Time 10:29 AM

Harper College
DentalProfile I

Date 11/2/2021

Patient Name: Birth Date: Date Created:

Please tell us about your dental history. By disclosing your previous dental experience, we at Harper College Dental Hygiene Clinic can help you achieve your oral hygiene goals, alleviate any dental

Primary Dentist Information

Do you have a primary dentist? If yes, please provide their address and phone number.	◯ Yes ◯ No	If yes	
Have you been to a dentist before? If yes, when was your last visit and how often do you usually go to the dentist?	◯ Yes ◯ No	If yes	
Have you had your teeth scaled and polished? If yes, when was the last time?	◯ Yes ◯ No	If yes	
Have you had any dental x-rays? If yes, when and how many?	◯ Yes ◯ No	If yes	
Was all recommended treatment completed? If yes, what was done?	◯ Yes ◯ No	If yes	

Dental History

In general, do dental visits cause you much concern?	◯ Yes ◯ No	If yes	
Have you experienced any difficulty with past dental treatemnt?	◯ Yes ◯ No	If yes	
Are you having any discomfort or pain at this time?	◯ Yes ◯ No	If yes	
Do sweets or cold bother your teeth?	◯ Yes ◯ No	If yes	
Does heat or pressure bother your teeth?	◯ Yes ◯ No	If yes	
Do you/ have you had problems with teeth or restorations (fillings) breaking?	◯ Yes ◯ No	If yes	
Does your jaw hurt or feel tight when you open wide, take a big bite, or when you awaken?	◯ Yes ◯ No	If yes	
Does your jaw ever make noise?	◯ Yes ◯ No	If yes	
Do you/have you had frequent headaches or neck pain?	◯ Yes ◯ No	If yes	
Do you/ have you had a cold sore or canker sore?	◯ Yes ◯ No	If yes	
Do you have any blisters, swelling or sores on your gums, roof or floor of your mouth, cheeks or lips?	◯ Yes ◯ No	If yes	
Do you/have you had any bleeding gums during brushing or for no apparent reason?	◯ Yes ◯ No	If yes	
Are your gums frequently sore or tender?	◯ Yes ◯ No	If yes	
Do you/have you had a bad taste in your mouth or mouth odor?	◯ Yes ◯ No	If yes	
Do you think you have problems with your gums and or supporting tooth structurs (loose, tipped, or shifted teeth)?	◯ Yes ◯ No	If yes	
Did one or both of your parents lose all of their teeth?	◯ Yes ◯ No	If yes	
Are you dissatified with the appearance of your teeth?	◯ Yes ◯ No	If yes	
Is there anything else in your dental history we should know about?	◯ Yes ◯ No	If yes	

Do you have any of the following habits?

Breathe through your mouth awake or asle	◯ Yes ◯ No	Biting your fingernails	◯ Yes ◯ No	Clenching your teeth	◯ Yes ◯ No	Grinding your teeth	◯ Yes ◯ No
Chewing on lips or cheek	◯ Yes ◯ No	Chewing on pens or pencils	◯ Yes ◯ No	Tongue thrusting	◯ Yes ◯ No	Thumb sucking	◯ Yes ◯ No

Have you ever had any of the following?

Oral surgery	◯ Yes ◯ No	Gum surgery	◯ Yes ◯ No	Orthodontics/braces	◯ Yes ◯ No	Root canal	◯ Yes ◯ No
Fixed bridgework	◯ Yes ◯ No	Dentures or removable partials	◯ Yes ◯ No	Bonding or veneers	◯ Yes ◯ No	Implants	◯ Yes ◯ No
Sealants	◯ Yes ◯ No						

Nutrition/Diet

How would you best describe your diet? (Check all that apply)

- ☐ Three meals per day, no snacks
- ☐ Three meals per day plus snacks
- ☐ Fewer than three meals per day plus snac
- ☐ More than three meals per day plus snack
- ☐ Gluten free
- ☐ Dairy free
- ☐ Vegan
- ☐ Vegetarian
- ☐ Reduced sodium
- ☐ Reduced fat
- ☐ Other

Please check the types of snacks you typically eat in a day.

Candy/mints	☐	If yes	
Cough drops	☐	If yes	
Cakes/pies/doughnuts	☐	If yes	
Jellies/jams/honey/syrup/dried fruit	☐	If yes	
Pop/soda/fruit drink	☐	If yes	
Energy drinks	☐	If yes	
Other	☐	If yes	

Please check the following oral hygiene aids that you use and comment on the frequency of that use as well as the product brand.

Manual toothbrush	☐	If yes	
Power/electric toothbrush	☐	If yes	
Floss	☐	If yes	
Water flosser/irrigator	☐	If yes	
Toothpick(s)	☐	If yes	
Interdental (Proxabrush) brush	☐	If yes	
Floss/bridge threaders	☐	If yes	
Stimudent(s)	☐	If yes	
Rubber tip stimulator	☐	If yes	
Perio Aid	☐	If yes	
Mouthwash	☐	If yes	
Fluoride	☐	If yes	
Toothpaste	☐	If yes	
Other	☐	If yes	

Additional Comments:

Signatures

I hereby acknowledge that the information provided is accurate. Parent or guardian will proved information and signature when patient is a minor.

Signature of Patient, Parent or Guardian:

X Date:_____

Signature of Student Dental Hygienist:

X Date:_____