



Dental Solutions Riad Almasri, D.D.S.

3102 Oak Lawn Ave, Suite 204
Dallas, TX 75219
214-521-5900

DENTAL HISTORY

Previous Dentist Name _____ Phone _____

Date of last exam _____ What was done at that visit? _____

Yes No Have you ever been told you need to pre-medicate for a dental visit? Please list medication _____

Yes No Have any of your teeth been lost or removed? Please indicate what teeth and date of loss _____

Yes No Have the teeth been replaced? _____

Yes No Are you happy with the replacement? _____

Yes No Have you ever had gum treatment, gum surgery, or deep cleaning? When? _____

Yes No Have you ever had orthodontic work? When? _____

Yes No Do you currently wear retainers? (upper or lower / both?) _____

Yes No Do you currently wear a TMJ or clenching/grinding appliance? (upper or lower?) _____

Yes No Have you experienced pain or soreness in the muscles of your face or around your ear? _____

Yes No Does your jaw click or pop? _____

Yes No Do you have frequent headaches, neck aches, or sore shoulders? _____

Yes No Does food get caught in your teeth? Where? _____

Yes No Are your teeth sensitive to hot, cold, sweets, or pressure? _____

Yes No Are you happy with the appearance of your teeth? _____

Yes No Do you feel your breath is offensive at times? _____

Yes No Is there anything additional you would like us to know about your previous dental treatment? _____

How often do you brush your teeth? _____ Floss? _____

Purpose of today's visit _____

Describe any dental problems or needs you are aware of _____

Describe any questions you may have regarding improving the appearance of your teeth _____