HAWAII HOLISTIC DENTISTRY

David T. Doi, DDS
Trevor Hartwell, DDS

Dental History

Patient's Name _____

On a holistic scale from 1-10 how do you rate your overall health? _____

Why are you seeking dental treatment? _____

How long since you have been to a dentist? _____

What was done then? _____

Name of last dentist: _____

Have you had dental X-rays taken in the last 2 years? ☐ Yes ☐ No

If YES: Name and location of dental office _____

When was your last cleaning? _____

How often did you visit a dentist before your last visit? _____

How often do you brush your teeth? _____How often do you floss? _____

Please CIRCLE Yes or No for the following questions. If you are unsure, please do not answer.

Yes	*No*	Do you use anything else to clean your teeth and gums? If so, what is it?
Yes	*No*	Are you satisfied with appearance of your teeth?
Yes	*No*	Have you ever had your teeth straightened?
Yes	*No*	Have you experienced any complications with extractions?
Yes	*No*	Are any teeth sensitive to hot?
Yes	*No*	Are any teeth sensitive to cold?
Yes	*No*	Are any teeth sensitive to sweets?
Yes	*No*	Are any teeth sensitive to chewing?
Yes	*No*	Do you have bleeding gums?
Yes	*No*	Does food wedge between your teeth?
Yes	*No*	Do you grind your teeth?
Yes	*No*	Have you ever had gum treatments?
Yes	*No*	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
Yes	*No*	Do you often feel tired, fatigued or sleepy during the day?
Yes	*No*	Has anyone observed you stop breathing during you sleep?
Yes	*No*	Do you feel you may have bad breath?
Yes	*No*	Have you ever noticed an unpleasant taste in your mouth?
Yes	*No*	Does your jaw frequently pop or click?
Yes	*No*	Do you have any nasal obstruction?
Yes	*No*	Have you had sores in your mouth?
Yes	*No*	Do you have any difficulty opening your mouth?
Yes	*No*	Do you have any difficult chewing?
Yes	*No*	Are you aware of any swelling or lump under your chin or along your neck?
Yes	*No*	Are you aware of any swelling or lump in your mouth?
Yes	*No*	Are you happy with your previous dental work?
Yes	*No*	Were there any complications or problems with your last dental treatment?

Signature _____ Date / / Reviewed by _____

Doctor's Notes: