HFD
HAMMOUD
FAMILY DENTAL

Omran Hammoud, D.D.S.
5777 West Maple Road
Suite 160
West Bloomfield, MI 48322
248-851-2980

DENTAL HISTORY

Patient Name: _____Date:_____

1. Have you been under regular care by a dentist?	☐ Yes	☐ No
2. When and for what was your last dental visit?_____		
3. Would you like to improve the appearance of your teeth?	☐ Yes	☐ No
4. Are you fearful of dental treatment?	☐ Yes	☐ No
5. Are you in any discomfort at this time?	☐ Yes	☐ No
6. Do your gums bleed when you brush?	☐ Yes	☐ No
7. Do you have any loose teeth?	☐ Yes	☐ No
8. Do you have frequent bad tastes in your mouth?	☐ Yes	☐ No
9. Do you hear popping or clicking around your ears or jaw joint?	☐ Yes	☐ No
10. Do you clench or grind your teeth and /or wear a bite guard?	☐ Yes	☐ No
11. Do you feel any lumps or swelling in your mouth or neck?	☐ Yes	☐ No
12. Have you had Orthodontic treatment (braces)?	☐ Yes	☐ No
13. Have you had Periodontal treatment (gum surgery)?	☐ Yes	☐ No
14. Have you had complications following extractions?	☐ Yes	☐ No
15. Is your primary drinking water fluoridated?	☐ Yes	☐ No
16. Do you have a fear of needles?	☐ Yes	☐ No
17. Have you ever had dental treatment using nitrous oxide (laughing gas)?	☐ Yes	☐ No
18. How would you grade your oral hygiene? (circle one) A B C D E		