



## ORAL & DENTAL HISTORY

Today's Date

Patient Name  Age  Sex:  Female  Male

***In order to assess your pet's oral health, we would appreciate if you could provide us with some important information by answering the following questions:***

Approximately how long have you had your pet and how did you acquire him/her?

What is your pet's normal diet? \_\_\_\_\_

Do you provide any at-home oral care for your pet?  Yes  No If so, what and how often? \_\_\_\_\_

When was the last time your pet had an oral exam by a veterinarian (approximate)? \_\_\_\_\_

When was the last time your pet had a dental cleaning performed under anesthesia? Was there anything done other than a routine cleaning (i.e. extractions, biopsy, etc)? \_\_\_\_\_

\_\_\_\_\_

Please describe the reason for your visit today and when you first became aware of this concern.

\_\_\_\_\_

Is this a recurring problem?  Yes  No Did your family veterinarian discover the problem(s)?  Yes  No  
Has this problem been previously treated?  Yes  No Explain: \_\_\_\_\_

1. Decreased appetite: <input type="radio"/> Yes <input type="radio"/> No	5. Broken tooth: <input type="radio"/> Yes <input type="radio"/> No
2. Abnormal chewing: <input type="radio"/> Yes <input type="radio"/> No	6. Oral growth: <input type="radio"/> Yes <input type="radio"/> No
3. Halitosis (bad breath): <input type="radio"/> Yes <input type="radio"/> No	7. Oral pain or sensitivity: <input type="radio"/> Yes <input type="radio"/> No
4. Excessive salivation/drooling: <input type="radio"/> Yes <input type="radio"/> No	

Are there any other symptoms of oral problems or dysfunction? \_\_\_\_\_

Does your pet have a known heart murmur or other cardiovascular problem?:  Yes  No

Does your pet have any other health problems?  Yes  No List these: \_\_\_\_\_

If your pet is scheduled for an anesthetic procedure today, please verify the last time they had anything to eat:

\_\_\_\_\_