Saskatchewan Health Authority

Resident Label

Name: _____

HSN: _____

D.O.B.:_____

LONG TERM CARE
ORAL HEALTH PROGRAM

DENTAL HISTORY

1. When was your last dental exam? _____
2. When were your last dental x-rays taken? _____
3. Are your teeth sensitive to: ☐ Cold ☐ Heat ☐ Sweets
4. Do you have bad breath or a bad taste in your mouth? ☐ Y ☐ N
5. Do your jaws crack, pop or grate when you open or close? ☐ Y ☐ N
6. Do you grind or clench your teeth? ☐ Y ☐ N
7. Do you have food catch between your teeth? ☐ Y ☐ N
8. Have you ever had any of the following?

   ☐ Bridgework ☐ Crowns or caps ☐ Dental implants
   ☐ Gum surgery ☐ Complete dentures ☐ Root canal treatment
   ☐ Partial dentures

9. Are complete dentures and/or partial dentures labelled with resident's name? ☐ Y ☐ N
10. If you wear dentures, do you have any concerns about your current dentures? ☐ Y ☐ N

    If yes, what?

    _____

    _____

11. Do you have any other concerns at this time about your oral health?

    _____

    _____