

DENTAL HISTORY

For

Patient Name: _____

What is the reason for your visit today? _____

Date of last dental visit _____ Last dental cleaning _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____

Phone _____ State _____ Zipcode _____

How often do you have dental examinations? _____

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

What toothpaste do you use? _____

What mouthwash do you use? _____

What other dental aids do you use? _____

Do you have any dental problems now? Yes No If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors/bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

Do your gums bleed or hurt?

Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No
If yes, where? _____		

Do you:

Clench or grind your teeth while awake or sleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign object with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew any tobacco products?	Yes	No

Is Whitening your teeth any interest to you? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

Have you ever had:

Orthodontic Treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including cause _____		

Have you experienced?

Clicking or popping of the jaw?	Yes	No
Pain? (Joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your

teeth's appearance? Yes No

Do you feel nervous about having dental
treatment? Yes No

If so what is your biggest concern? _____

Have you ever experienced an
upsetting dental experience? Yes No

If yes, please describe _____