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Dental History

Patient Name_____ Birth Date _____

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-Rays _____

What was done at your last dental visit? _____

Previous Dentist's Name, Address and Phone Number _____

_____

How often do you have dental examinations? _____

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

What other dental aids do you use? (electric toothbrush, toothpick, etc) _____

Do you have any dental problems now? If so, 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 or bad tastes?	Yes	No
Do you frequently get cold sore, blisters or any other oral lesions?	Yes	No
Do you gums bleed or hurt?	Yes	No
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 get caught between your teeth?	Yes	No

Is yes, where?_____

Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects 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 tobacco or use other tobacco products?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or your 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_____
_____

Have you ever experienced:		
Clicking or popping of the jaw?	Yes	No
Pain in your jaw, ear, side of face?	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck or 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 had an upsetting dental experience?	Yes	No

If yes, please describe _____
_____

Is there anything else about having dental treatment that you would like us to know? If yes, please describe _____

_____

_____