DENTAL HISTORY

(name)	(patient account #)

1. What is the reason for your visit today?_____

Date of your last dental visit?_____ Last Cleaning?_____ Last full mouth x-rays?_____

2. What was done at your last dental visit?_____

_____

Previous Dentist's name:_____
Address_____ City_____ State_____
Telephone_____

3. 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, Interplak, toothpick, proxybrush, etc.)?_____

_____

4. Do you have any dental problems/concerns now? Yes/no
If yes, please describe:_____

Are any of your teeth sensitive to:
- Hot or cold? Yes/no
- Sweets? Yes/no
- Biting/Chewing Yes/no

Noticed any mouth odors or bad tastes? Yes/no
Get cold sores/canker sores Yes/no

Do your gums bleed or hurt? Yes/no
Have your parents experienced gum disease or tooth loss? Yes/no
Have you noticed any loose teeth or a change in your bite? Yes/no
Does food tend to get caught between your teeth? Yes/no
If yes, where?_____

Do you:
Clench/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, etc.) Yes/no
Mouth breathe while awake or sleeping? Yes/no
Have tired jaws, especially in the morning? Yes/no
Smoke/Chew tobacco? Yes/no
If yes, how much?_____

Have you ever had:
Orthodontic treatment? Yes/no
Oral surgery? Yes/no
Periodontal treatment? Yes/no
Bite adjusted? Yes/no
Serious injury to mouth/head? Yes/no
If yes, please describe:_____

_____

Have you ever experienced:
Clicking or popping of the jaw? Yes/no
Pain (ear/jaw/side of face)? Yes/no
Difficulty opening or closing your mouth? Yes/no
Difficulty in chewing on either side of you mouth? Yes/no
Headaches, neck aches, or shoulder aches? Yes/no
Sore muscles (neck, shoulders)? Yes/no

Are you satisfied with the appearance of your teeth? Yes/no
Would you like to keep all of your teeth all of your life? Yes/no
Do you feel nervous about having dental treatment? Yes/no
If yes, 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? Yes/no
If yes, please describe_____

_____