

DENTAL HISTORY

(name) _____	(patient account #) _____
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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

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: _____

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 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 _____