DENTAL HISTORY

Patient Name_____

What is the reason for your visit today?_____

Date of Last Dental Visit_____Last Dental Cleaning_____

Previous Dentist's Name_____

Address_____Telephone_____

How often do you have dental examinations?_____How often do you brush your teeth?_____

How often do you floss?_____Have you ever or are you currently using fluoride? Yes No

What other dental aids do you use? (interplak, toothpick, ect.)_____

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 taste?	Yes No
Do you frequently get cold sores, blisters or any other oral lesions?	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 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 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 Surger?	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
Difficulty in chewing on either side?	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
Would you like to keep all your teeth all your life	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?

If yes, please describe_____

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

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

If yes, please describe_____

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