DENTAL HISTORY

PATIENT NAME_____

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 visit?
_____
Previous Dentist's name_____Telephone_____
Address_____State_____Zip_____
_____

How often do you have dental examination?
_____
How often do you brush your teeth?_____How often do you floss?
_____
What other dental aids do you use? (waterpick, toothpick, etc.)_____

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

Are any of your teeth sensitive to: Temperature? yes no sweet? yes no biting? yes no

yes no Have you noticed any mouth odors or bad tastes?
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?
If yes, where?
_____

yes no Do you clench or grind your teeth while awake or asleep?
yes no Do you have tired jaws, especially in the morning?
yes no Do you have any sleeping disorders or snore?
yes no Do you smoke, chew or use other tobacco products?

Have you ever had: orthodontic treatment? yes no oral surgery? yes no periodontal treatment? yes no

yes no Have you ever had a serious injury to the mouth or head?
If yes, please describe, including cause_____

yes no Have you experienced pain, clicking or popping of the jaw?
yes no Are you satisfied with your teeth's appearance?
yes no Would you like to keep all of you teeth all of your life?
yes no Do you feel nervous about having dental treatment?

If yes, what is your biggest concern?
_____

yes no Have you ever had an upsetting dental experience?
If yes, please
describe_____

yes no Is there anything else about having dental treatment that you would like us to know?
If yes, please
describe_____
_____
_____
_____