DENTAL HISTORY

Name: _____ Date_____

What is the reason for your visit today? _____
_____

Date of Last Dental Visit: _____ Last Dental Cleaning: _____ Last Full Mouth X-Rays: _____
Previous Dentist's Name_____ City/State _____
How often do you have dental examinations? _____
How often do you brush your teeth? _____ Do you use a manual or electric toothbrush? _____
How often do you floss? _____ Do you use mouthwash? _____
What other dental aids do you use? (Interplak, toothpick, etc.) _____

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

Are any of your teeth sensitive to:
Hot or Cold? Yes No
Sweets? Yes No
Biting or Chewing? Yes No

Your mouth:
Have you noticed mouth odors or bad tastes? Yes No
Do your gums bleed or hurt? Yes No
Have you noticed loose teeth or change in bite? Yes No
Does food get caught between your teeth? Yes No

Your parents:
Have your parents experienced gum disease? Yes No
Have your parents experienced early tooth loss? Yes No

Do you:
Frequently get cold sores, blisters or Yes No
Any other lesions? Yes No
Clench or Grind your teeth? Yes No
Bite your lips or cheeks regularly? Yes No
Hold foreign objects with your teeth? Yes No
Mouth breath while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No

Have you ever had:
Orthodontic treatment? Yes No
Oral surgery? Yes No
Periodontal treatment? Yes No
A serious injury to the mouth or head? Yes No
Your teeth ground down or bite adjusted? Yes No
A bite plate or mouth guard? Yes No

Have you experienced:
Clicking or popping of the jaw? Yes No
Pain? (joint, ear, side of face) Yes No
Difficulty opening/closing mouth? Yes No
Headaches, neckaches or shoulder aches? Yes No
Sore muscles (neck, shoulders)? Yes No

Your smile:
Are you satisfied with your teeth? Yes No
Would you like to keep all your teeth? Yes No

Dental treatment:
Do you feel nervous about treatment? Yes No
Have you ever had an upsetting experience? Yes No

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

If yes, please describe: _____
_____
_____