

DENTAL HISTORY

Patient Name _____

1. What is the reason for your visit today? _____
2. Date of last dental visit _____ Last dental cleaning _____ Last xrays _____
3. What was done at your last dental visit? _____
4. Previous dentist's name _____
 Address _____ City _____ State _____
 Telephone _____
5. How often do you have dental examinations? _____
6. How often do you brush your teeth? _____ How often do you floss? _____
7. What other dental aids do you use? (sonicare, toothpick, rubber tip, etc) _____
8. Do you have any dental problems now? Yes No
 If yes, please describe _____

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|---|--|
| <p>Are any of your teeth sensitive to:</p> <p>Yes No Hot or cold</p> <p>Yes No Sweets</p> <p>Yes No Biting or chewing</p> <p>Yes No Have you noticed any mouth odors or bad tastes?</p> <p>Yes No Do you frequently get cold sores, blisters or any other oral lesions?</p> | <p>Have you ever had:</p> <p>Yes No Orthodontic treatment</p> <p>Yes No Oral Surgery</p> <p>Yes No Periodontal treatment</p> <p>Yes No Your teeth ground or bite adjusted</p> <p>Yes No A nightguard or bitesplint</p> <p>Yes No A serious injury to the mouth or head</p> <p>If so, please describe, including cause: _____</p> |
| <p>Yes No Do your gums bleed or hurt?</p> <p>Yes No Have your parents experienced gum disease or tooth loss?</p> <p>Yes No Have you noticed any loose teeth or change in your bite?</p> <p>Yes No Does food tend to become caught in between your teeth?</p> <p>If yes, where? _____</p> | <p>Have you experienced:</p> <p>Yes No Clicking or popping of the jaw</p> <p>Yes No Pain in jaw joint, ear or side of face</p> <p>Yes No Difficulty in opening or closing mouth</p> <p>Yes No Difficulty in chewing on either side of mouth</p> <p>Yes No Headaches, neckaches or shoulder aches</p> <p>Yes No Sore muscles in neck or shoulders</p> |
| <p>Do you:</p> <p>Yes No Clench or grind your teeth while awake or asleep</p> <p>Yes No Bite your lips or cheeks regularly</p> <p>Yes No Hold foreign objects with your teeth such as pencils, pins, nails, pipe, fingernails</p> <p>Yes No Mouth breathe while awake or asleep</p> <p>Yes No Have sore jaw muscles in the morning</p> <p>Yes No Smoke or chew tobacco</p> | <p>Yes No Are you satisfied with your teeth's appearance?</p> <p>Yes No Do you feel nervous about having dental treatment?</p> <p>If so, what is your biggest concern? _____</p> <p>Yes No Do you use nitrous oxide (laughing gas) for dental treatment?</p> <p>Yes No Have you ever had an upsetting dental experience?</p> <p>If yes, please describe _____</p> |

If there is anything else about having dental treatment that you would like us to know, please describe:

Patient / Guardian Signature _____ Date _____