DENTAL HISTORY

What is the reason for your visit today? _____

Previous Dentist's Name _____ Address _____

Date of Last Visit _____ Last Hygiene Visit _____ Last X-Rays _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you have any dental problems? Yes☐ No☐

If yes, please describe _____

Are any of your teeth sensitive to:

Hot or Cold?	Yes ☐	No ☐
Sweets?	Yes ☐	No ☐
Biting or pressure?	Yes ☐	No ☐
Have you ever noticed any mouth odors or bad taste?	Yes ☐	No ☐
Do you frequently get cold sores, blisters or any 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 between your teeth?	Yes ☐	No ☐

Do you:

Clench or grind your teeth while awake or asleep?	Yes ☐	No ☐
Have tired jaws, especially in the morning?	Yes ☐	No ☐
Bite your lips or cheeks regularly?	Yes ☐	No ☐
Hold foreign objects with your teeth? (pencils, pins, nails, fingernails, pipe)	Yes ☐	No ☐
Mouth breather while asleep or awake?	Yes ☐	No ☐
Snore?	Yes ☐	No ☐

Have you ever experienced:

Clicking or popping of the jaw?	Yes ☐	No ☐
Pain? (Joint, ear, side of face)	Yes ☐	No ☐
Difficulty opening or closing the mouth?	Yes ☐	No ☐
Frequent headaches, neckaches, or shoulder aches?	Yes ☐	No ☐
Any pain or soreness in the muscles of your face or around the ears?	Yes ☐	No ☐

Have you ever had:

Orthodontic treatment?	Yes ☐	No ☐
Oral surgery?	Yes ☐	No ☐
Teeth removed?	Yes ☐	No ☐
If so, have they been replaced?	Yes ☐	No ☐
Fixed Bridge?	Yes ☐	No ☐
Removable Partial?	Yes ☐	No ☐
Complete Denture?	Yes ☐	No ☐
Implants?	Yes ☐	No ☐
Are you happy with the replacement?	Yes ☐	No ☐
Periodontal Treatment?	Yes ☐	No ☐
Gum Surgery?	Yes ☐	No ☐
If so, when?		
By whom?		
Your teeth ground or the bite adjusted?	Yes ☐	No ☐
A serious injury to the mouth or head?	Yes ☐	No ☐

If so, please describe. Include cause. _____

Do you like the appearance of your teeth; your smile?	Yes ☐	No ☐
Do you like the color of your teeth?	Yes ☐	No ☐
Are your teeth as straight as you would like?	Yes ☐	No ☐

What would you like to change most in the appearance of your teeth? _____

Do you feel anxiety about having dental treatment?	Yes ☐	No ☐
Have you ever had an upsetting dental experience?	Yes ☐	No ☐

If yes, please describe, _____

How did you overcome your anxiety? _____

Is there anything else about having dental treatment that you would like us to know, please describe. _____

DR. COMMENTS:

I consent to the doctor's exam and necessary diagnostics for treatment including x-rays.

Patient Signature _____ Date _____
(PARENT/GUARDIAN OF A MINOR)

Doctor Signature _____ Date _____