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…… Yes ❒ No ❒
Or bad taste? …… Yes❒ No ❒
Do you frequently get cold sores, …… Yes ❒ No ❒
Blisters or any lesions?…… Yes ❒ No ❒
Do your gums bleed or hurt? …… Yes ❒ No ❒
Have your parents experienced…… Yes ❒ No ❒
Gum disease of tooth loss? …… Yes ❒ No ❒
Have you noticed any loose teeth or…… Yes ❒ No ❒
Change in your bite?…… Yes ❒ No ❒
Does food tend to become caught…… Yes ❒ No ❒
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 ❒
Do you mouth breath while you sleep or…… Yes ❒ No ❒
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,…… Yes ❒ No ❒
Or shoulder aches? …… Yes ❒ No ❒
Any pain or soreness in the muscles of…… Yes ❒ No ❒
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…… Yes❒ No ❒
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?…… Yes❒ No ❒
By whom?…… Yes❒ No ❒
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;…… Yes❒ No ❒
your smile?…… Yes❒ No ❒
Do you like the color of your teeth?…… Yes❒ No ❒
What would you like to change most in the
Appearance of your teeth?_____
_____

Do you feel anxiety about having dental treatment?
Have you ever had an upsetting
dental experience?
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._____

I consent to the doctors exam and necessary diagnostics for treatment including x-rays.

Patient Signature_____ **Date** _____
(PARENT/GUARDIAN OF A MINOR)
Doctor Signature_____ **Date** _____