west end dental
comprehensive & aesthetic dentistry

Patient Name_____

Date of Birth_____

DENTAL HISTORY FORM

1. Purpose of initial visit _____
   _____
2. Are you aware of a problem? _____
   _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
   _____
5. Previous dentists name _____
   Address _____Tel._____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits?. . . . . YES NO
   How often: _____
8. Were dental x-rays taken? . . . . . .YES NO
9. Have you lost any teeth or have any teeth been removed? . . . . . .YES NO
   Why? _____
10. Have they been replaced? . . . . . .YES NO
11. How have they been replaced?
    a. Fixed bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Denture _____ Age _____
    d. Implant _____ Age _____
12. Are you unhappy with the replacement? . . . . . YES NO
    If yes, explain _____
13. Would you like to know about permanent replacements? . . . . . YES NO
14. Have you ever had any problems/complications with previous dental treatment? YES NO
    If yes, explain _____
15. Do you clench or grind your teeth? . . . . . YES NO
16. Does your jaw click or pop? . . . . . .YES NO
17. Have you ever experienced any pain or soreness in the muscles of your face or around your ear? . . . . . YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? . . . . . .YES NO
19. Does food get caught in your teeth? . . . . . YES NO

20. Are any of your teeth sensitive to (Circle all that apply) Hot Cold Sweets Pressure
21. Do your gums bleed or hurt? . . . . . YES NO
    When? _____
22. How often do you brush your teeth? _____ When? _____
23. Do you use dental floss? . . . . . YES NO
    How often? _____
24. Are any of your teeth loose, tipped, shifted or chipped? . . . . . YES NO
25. Are you unhappy with the appearance of your teeth? . . . . . YES NO
26. Do you feel like you have a "gummy" smile?. . . . . YES NO
27. Are there any areas of your front teeth that show "black triangles" between the teeth?_____
28. Have you been prescribed CPAP or an oral appliance for sleep apnea? . . . . . YES NO
29. How do you feel about your teeth in general?
    _____

30. Do you feel your breath is offensive at times? . . . . . .YES NO
31. Have you ever had gum treatment or surgery? . . . . . YES NO
    What? _____
    Where? _____
    When? _____
32. Have you ever had orthodontic work? _____
33. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?
    _____
34. Do you have any questions or concerns? . . . . . YES NO

COMMENTS:

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE_____ DATE _____

Revised 11/22/17