Patient Name

DENTAL HISTORY

Medical Alert _____

What is the reason for today's visit? _____

_____ Date: _____

Date of last dental visit _____ Last dental cleaning _____ Last full mouth X-rays _____

What was done at your last dental visit? _____

If you wish us to obtain your previous dental records, please provide the following:

Previous dentist's name _____ Telephone _____

Address _____

How often do you have dental examinations? _____

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

What other dental aids do you use? ☐ Electric toothbrush ☐ Toothpick ☐ Water irrigator ☐ Other _____

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
Have you noticed any mouth odors or bad tastes? ☐ Yes ☐ No
Do you frequently get cold sores, blisters or any other oral 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 in between your teeth? ☐ Yes ☐ No
If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? ☐ Yes ☐ No
Bite your lips or cheeks regularly? ☐ Yes ☐ No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) ☐ Yes ☐ No
Mouth breathe while awake or asleep? ☐ Yes ☐ No
Have tired jaws, especially in the morning? ☐ Yes ☐ No
Smoke, chew tobacco? ☐ Yes ☐ No
Are you interested in stopping smoking? ☐ Yes ☐ No

Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No
Oral surgery? ☐ Yes ☐ No
Periodontal treatment? ☐ Yes ☐ No
Your teeth ground or the bite adjusted? ☐ Yes ☐ No
A bite plate or mouth guard? ☐ Yes ☐ No
A serious injury to the mouth or head? ☐ Yes ☐ No
If so, please describe, including cause: _____

_____

Have you experienced:

Clicking or popping of the jaw? ☐ Yes ☐ No
Pain? (joint, ear, side of face) ☐ Yes ☐ No
Difficulty in opening or closing the mouth? ☐ Yes ☐ No
Difficulty in chewing on either side of the mouth? ☐ Yes ☐ No
Headaches, neck or shoulder aches? ☐ Yes ☐ No
Sore muscles (neck, shoulders)? ☐ Yes ☐ No

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No
Would you like to improve your smile? ☐ Yes ☐ No
Would you be interested in teeth whitening? ☐ Yes ☐ No

Do you feel nervous about having dental treatment? ☐ Yes ☐ No
If so, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience? ☐ Yes ☐ No
If yes, please describe: _____

_____

Is there anything else about having dental treatment that you would like us to know? ☐ **Yes** ☐ **No**
If yes, please describe. _____

_____