DENTAL HISTORY

Patient Name:____

What is the reason for your visit today?____

Date of last Dental visit?_____________Last Cleaning?____________Last Full mouth x-rays?__________

What was done at your last dental visit?____

Name of your previous Dentist?____

Do you have Dental problems now?____

How often do you have dental examinations?____

How often do you brush your teeth?____

How often do you floss your teeth?____

Do you use a: water-pik, toothpick, electric toothbrush, other?_________________________________

Which of the following apply to you?

Are any of your teeth sensitive to:

- ☐ Hot or cold
- ☐ Sweets
- ☐ Biting or chewing
- ☐ Do you have mouth odors or a bad taste
- ☐ Cold sores, blisters, other oral lesions

Do you:

- ☐ Clench/grind teeth (while awake or asleep)
- ☐ Bite lips or cheeks regularly
- ☐ Hold foreign objects with your teeth (pencils,etc)
- ☐ Mouth breath while awake or asleep
- ☐ Have tired jaws, especially in the morning
- ☐ Smoke or chew tobacco

Have you ever had:

- ☐ Orthodontic treatment
- ☐ Oral surgery
- ☐ Periodontal treatment
- ☐ Your teeth ground or the bite adjusted
- ☐ A bite plate or mouth guard
- ☐ Had a serious injury to the mouth or head

If so please describe, including cause

____

____

Do your gums bleed or hurt?

- ☐ Gum Pain or bleeding
- ☐ Loose teeth or change in bite
- ☐ Food caught/stuck between teeth
- ☐ Parental history of gum disease
- ☐ Parental history of tooth loss

Have you ever experienced:

- ☐ Clicking or popping of jaw
- ☐ Pain (joint, ear, side of face)
- ☐ Difficulty in opening or closing the mouth
- ☐ Difficulty in chewing on either side of the mouth
- ☐ Headaches, neck aches or shoulder aches
- ☐ Sore muscles (neck, shoulders)

Do you feel nervous about having dental treatment? ☐ No ☐ Yes If yes, explain ____

Do you have any concerns about dental treatment? ☐ No ☐ Yes If yes, explain ____

Have you ever had an upsetting dental experience? ☐ No ☐ Yes If yes, explain ____

Is there anything standing in the way of you getting necessary dental treatment? ☐ No ☐ Yes If yes, explain ______________________

My main concerns are:____

What would you like us to know about?____

Who may we contact in case of emergency? Name ____

Relationship___________________________Primary Phone__________________________Secondary phone______________________

Comments: ____