DENTAL HISTORY

1. What is the reason for today's visit?_____

_____

2. Date of Last Dental Visit_____ Last Cleaning_____Last Full Mouth X-Rays _____ _____

3. What was done at your last dental visit? _____

_____

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

Previous Dentist's Name_____ Telephone: _____

Address_____

5. How often do you have dental examinations? _____

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

7. What other dental aids do you use? Electric Toothbrush_____ Toothpick_____ Water Irrigator_____ Other _____

8. Do you have any dental problems now? Yes _____ No _____

If yes, please describe: _____

_____

Are any of your teeth sensitive to:			**Have you ever had:**		
Hot or cold?	Yes	No	Orthodontic treatment?	Yes	No
Sweets?	Yes	No	Oral surgery?	Yes	No
Biting or Chewing?	Yes	No	Periodontal treatment?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No	Your teeth ground or the bite adjusted?	Yes	No
			A bite plate or mouth guard?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No	A serious injury to the mouth or head?	Yes	No
			If so, please describe, including cause _____		
			_____		
Do your gums bleed or hurt?	Yes	No	**Have you experienced:**		
Have your parents experienced gum disease or tooth loss?	Yes	No	Clicking, popping or grating sounds of the jaw?	Yes	No
			Pain? (joint, unexplained teeth or face, behind the eyes)?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No	Difficulty in opening or closing the mouth (locking jaw)?	Yes	No
			Limited mouth opening?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No	Headaches, neck aches or shoulder aches?	Yes	No
			Sore or stiff muscles (jaws, neck, shoulders)?	Yes	No
If yes where?			Snoring or Sleep Apnea?	Yes	No
_____			Ear aches, stuffiness or ringing of the ears?	Yes	No
			Difficulty swallowing?	Yes	No
Do you:			**Are you satisfied with your teeth's appearance?**	Yes	No
Clench or grind your teeth while awake or asleep	Yes	No	Would you like to keep your teeth all of your life?	Yes	No
			Would you like to improve your smile?	Yes	No
Bite your lips or cheeks regularly?	Yes	No	**Do you feel nervous about having dental treatment?**	Yes	No
Hold foreign, objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No	If so what is your biggest concern?_____		
Regularly chew ice or other hard foods?	Yes	No			
Mouth breathe while awake or asleep?	Yes	No	**Have you ever had an upsetting dental experience?**	Yes	No
Have tired jaws, especially in the morning?	Yes	No	If yes, please describe: _____		
Smoke and/or chew tobacco?	Yes	No			
If yes, how much per day?_____					

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

_____

PATIENT NAME_____: DATE_____