

DENTAL HISTORY

1. Patient Name _____
2. What is the reason for your visit today? _____
3. Date of last dental visit _____ Last dental cleaning _____ Last full mouth X-Rays _____
4. What was done at your last dental visit? _____
5. Previous Dentist's Name _____
Address/State/Zip _____
Telephone _____
6. How often do you have dental examinations? _____
7. How often do you brush your teeth? _____ How often do you floss? _____
8. Have you ever used or are currently using topical fluoride? Yes No
9. What other dental aids do you use? (Waterpik, toothpick, etc.) _____
10. **Do you have any dental problems now?** Yes No
If yes, please describe. _____
11. Check any of the following which apply in either past or present:

| | |
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| <input type="checkbox"/> Hot or Cold Sensitivity <input type="checkbox"/> Sweets Sensitivity <input type="checkbox"/> Biting or Chewing Sensitivity <input type="checkbox"/> Experience bad odors or bad tastes <input type="checkbox"/> Frequent cold sores, blisters or other lesions <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Painful gums <input type="checkbox"/> Experienced gum disease <input type="checkbox"/> Have tooth loss <input type="checkbox"/> Loose teeth <input type="checkbox"/> Change in your bite <input type="checkbox"/> Food catches between your teeth <input type="checkbox"/> Clench or grind teeth while asleep <input type="checkbox"/> Clench or grind teeth while awake <input type="checkbox"/> Bite lips or cheek regularly <input type="checkbox"/> Hold foreign objects with teeth (i.e. pencil) <input type="checkbox"/> Mouth breathe while awake or asleep | <input type="checkbox"/> Snore or other sleeping disorders <input type="checkbox"/> Use, smoke, chew tobacco <input type="checkbox"/> Orthodontic treatment <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Periodontal treatment <input type="checkbox"/> Your teeth ground or bite adjusted <input type="checkbox"/> Received a bite plate or mouth guard <input type="checkbox"/> Clicking or popping of jaw <input type="checkbox"/> Pain (joint, ear, side of face) <input type="checkbox"/> Difficulty opening / closing mouth <input type="checkbox"/> Difficulty chewing on either side of mouth <input type="checkbox"/> Head, neck, or shoulder aches <input type="checkbox"/> Sore muscles (neck, shoulder) <input type="checkbox"/> A serious injury to the mouth or head? If so, please describe, including cause _____ <input type="checkbox"/> Experience tired jaws, especially in the morning |
|--|--|
12. Are you satisfied with your teeth's appearance?..... Yes No
13. Would you like to keep all of your teeth all of your life? Yes No
14. Do you feel nervous about dental treatment? Yes No
If so, what is your biggest concern? _____
15. Have you ever had an upsetting dental experience? Yes No
Please describe. _____
16. Have you ever been told to take a pre-medication prior to dental treatment? Yes No
17. Is there anything else you would like us to know? Please describe. _____