DENTAL HISTORY

Patient Name:____ Date of Birth:___________________

What is the reason for your visit today?____

Do you have any dental problems now? Yes:______ No:______

If yes, please describe:____

Date of Last Dental Exam:_______________ Last Dental Cleaning:_______________ Last X-rays:_______________

What was done at your last visit?____

Previous Dentist:____

Address:__________________________________ City:____________________ State:_____ Zip:___________

Have you made regular dental visits? Yes:______ No:______ How often?__________________________________

How often do you brush?___________________ How often do you floss?________________________________

What other dental aids do you use? (Waterpik, Interplak, Toothpick, etc.)__________________________________

1. Indicate which of the following you have had, or have presently. Check Yes or No to each item.

	Yes	No		Yes	No
Are any of your teeth sensitive to:			**Have you ever had:**		
Hot or Cold			Orthodontic Treatment		
Sweets			Oral Surgery		
Biting or Chewing			Periodontal Treatment		
Do you:			Teeth ground		
Clench or grind your teeth			Bit adjusted		
Bite your lips or cheeks			**Have you experienced:**		
Hold foreign objects with your teeth			Clicking or popping in jaw		
Mouth odors/bad tastes			Pain (joint, ear, side of face)		
Cold sores/blisters/oral lesions			Difficulty in opening or closing mouth		
Tired jaw in the morning			Difficulty chewing on either side of mouth		
Smoke/chew tobacco			Headaches, neck aches or shoulder aches		
Gums bleed or hurt			Sore muscles (neck or shoulders)		
Loose teeth or change in bite					
Have your parents experienced gum disease?			Are you satisfied with your teeth's appearance?		
Would you like to keep all your teeth all of your life?			Does food get caught between your teeth?		

2. Have you lost any teeth or had teeth removed? Yes:______ No:______
   If yes, why?____
3. Have they been replaced? Yes:______ No:______
   How? Fixed bridge:______ Partial:______ Denture:______ Implant:______
4. Are you happy with the replacement? Yes:______ No:______
   If no, why?____
5. Have you ever had a serious injury to your mouth or head? Yes:______ No:______
   If yes, please describe, including cause:____
6. Do you feel nervous about having dental treatment? Yes:______ No:______
   If yes, what is your biggest concern?____
7. Have you ever had an upsetting dental experience? Yes:______ No:______
8. If yes, please describe:____
9. Is there anything else about having dental treatment that you would like us to know? Yes:______ No:______
   If yes, please describe:____