DENTAL HISTORY

PATIENT NAME: ____ **DATE OF BIRTH:** _____________

What is the reason for your visit today? ____
Previous Dentist's name: ____
Date of last visit: _____________ Last teeth cleaning: ____________ Last x-rays: ________________
How often do you brush your teeth? _______________ How often do you floss? __________________

Are any of your teeth sensitive to:

Hot or Cold?………………………... Yes ☐ No ☐
Sweets?……………………………... Yes ☐ No ☐
Biting or pressure?………………… Yes ☐ No ☐

Have you noticed any mouth odors or bad taste?……………………… Yes ☐ No ☐
Do you frequently get cold sores, blisters, or any lesions?…………... Yes ☐ No ☐
Do your gums bleed or hurt?……….. Yes ☐ No ☐
Does periodontal/gum disease run in your family?……………………… Yes ☐ No ☐
Does food tend to become caught between your teeth?……………… Yes ☐ No ☐

Do you:

Clench or grind your teeth?………… Yes ☐ No ☐
Have tired jaws, especially in the morning…………………………... Yes ☐ No ☐
Bite your lips or cheeks regularly?…. Yes ☐ No ☐
Mouth breath while asleep or awake………………………….. Yes ☐ No ☐
Snore?………………………………. Yes ☐ No ☐
Participate on contact sports?……… Yes ☐ No ☐
If so, do you wear a mouth guard? Yes ☐ No ☐

Have you ever experienced:

Clicking or popping of the jaw?……. Yes ☐ No ☐
Pain? (joint, ear, side of face)………. Yes ☐ No ☐
Difficulty opening or closing your mouth?………………………. Yes ☐ No ☐
Frequent headache, neckaches, or shoulder aches?………………… Yes ☐ No ☐

Have you ever had:

Orthodontic treatment?……………. Yes ☐ No ☐
Oral surgery?………………………. Yes ☐ No ☐
Teeth removed?…………………… Yes ☐ No ☐
If so, have they been replaced?…... Yes ☐ No ☐
Fixed bridge?………………………. Yes ☐ No ☐
Removable partial?…………………Yes ☐ No ☐
Complete denture?…………………. Yes ☐ No ☐
Dental implants?…………………… Yes ☐ No ☐
Periodontal treatment?……………... Yes ☐ No ☐
Gum surgery?……………………… Yes ☐ No ☐
If so, when? ______________________________
By whom? _______________________________
Your teeth ground or the bite adjusted?…………………………. Yes ☐ No ☐
A serious injury to the mouth or head?………………………………Yes ☐ No ☐
If so, please explain: ________________________
____

Is there anything you would like to change about your teeth?……….Yes ☐ No ☐
If so, what? ______________________________

Do you feel anxiety about having dental treatment?…………………. Yes ☐ No ☐

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

I consent to the doctor's exam and necessary diagnostics for treatment including x-rays.

Patient Signature ____ Date ____________________________
(PARENT/GUARDIAN OF MINOR)

Doctor Signature ____ Date ____________________________