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PATIENT DENTAL HISTORY

What is the reason for your visit today?____

____

Date of Last Dental Visit:__________ Last Dental Cleaning:__________ Last Full Mouth X-Ray:__________

What was done at your last dental visit?____

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Previous Dentist's Name:______________________ Telephone:______________________

Address:______________________ City:______________ State:____ Zip:__________

How often do you have dental examinations?______________________________

How often do you brush your teeth?______________________________

What other dental aids do you use (Interplak, toothpicks, etc.)?______________________

Do you have any dental problems now? If so, please describe:______________________

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	YES	NO
Are any of your teeth sensitive to:		
Biting/Chewing	☐	☐
Hot/Cold	☐	☐
Sweets	☐	☐
Have you noticed any mouth odors?	☐	☐
Do you frequently get cold sores, blisters or any other oral lesions?	☐	☐
Please answer the following questions:		
Do your gums bleed or hurt?	☐	☐
Have your parents experienced gum disease or tooth loss?	☐	☐
Have you noticed any loose teeth or change in your bite?	☐	☐
Does food tend to become caught in between your teeth?	☐	☐
If yes, where?______________________		
Do you:		
Clench or grind your teeth while awake or asleep?	☐	☐
Bite your lips or cheeks regularly?	☐	☐
Hold foreign objects with your teeth such as pencils, pipe, pins, fingernails)?	☐	☐
Mouth breathe while awake or asleep?	☐	☐
Have tired jaws, especially in the morning?	☐	☐
Smoke/chew tobacco?	☐	☐

	YES	NO
Have you ever had:		
Orthodontic treatment	☐	☐
Oral surgery	☐	☐
Periodontal treatment	☐	☐
Your teeth ground or the bite adjusted?	☐	☐
A bite plate or mouth guard?	☐	☐
A serious injury to the mouth or head? If so, please describe, including cause:______________		
Have you experienced any of the following:		
Clicking or popping of the jaw?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty in opening or closing the mouth?	☐	☐
Headaches, neck aches or shoulder aches?	☐	☐
Sore muscles (neck, shoulders)?	☐	☐
Please answer the following questions:		
Are you satisfied with your teeth's appearance?	☐	☐
Would you like to keep all of your teeth all of your life?	☐	☐
Do you feel nervous about having dental treatment?	☐	☐
If so, what is your biggest concern?______________________		

Is there anything else about having dental treatment that you would like us to know? If yes, please describe (use the back of this form if you need more space):______________________

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