

DENTAL HISTORY

Patient Name: _____

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Phone Number _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How Often do you floss? _____

Have you ever used topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping aids?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever been told to take a pre-medication prior to dental treatment?

Is there anything else about dental treatment you would like us to know?

If yes, please describe? _____

Have you ever had:

Orthodontic Treatment	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?

Would you like to keep all of your teeth all your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
Have you ever had an upsetting dental experience?	Yes	No
Have you used whitening products before?	Yes	No
Are you interested in additional information about teeth whitening?	Yes	No
Are you interested in straightening your teeth and the different methods used?	Yes	No

Yes No

Yes No