

DENTAL HISTORY

What is the reason for your visit today? _____

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

General Dentist's Name: _____

Do you have any dental problems now? Yes _____ No _____

If yes, please describe _____

Are your teeth sensitive to:

Hot or cold? Yes No
Sweets? Yes No
Biting or chewing? Yes No
Continuous mouth odors/bad taste? Yes No
Do you frequently get cold sores, blisters or other oral lesions? Yes No

Have you ever had:

Dental Implants? Yes No
Orthodontic treatment? Yes No
Oral Surgery? Yes No
Periodontal treatment? Yes No
Serious injury to the mouth or head? Yes No
A bite plate or mouth guard? Yes No
Your teeth ground or bite adjusted? 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
If yes, where? _____

Have you experienced:

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

Do you:

Clench/grind teeth while awake/asleep? Yes No
Bite lips/cheeks regularly? Yes No
Hold foreign objects with your teeth? (pencils,pens,pipe,nails,fingernails) Yes No
Mouth breathe while awake or asleep? Yes No
Have tired jaws, especially in morning? Yes No
Smoke/chew tobacco? Yes No

Are you satisfied with the appearance of your teeth? Yes No

Would you like to keep your teeth all of your life? Yes No
Do you feel nervous about having dental treatment? Yes No
If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Doctor Signature

Date

