

DENTAL HISTORY

What's the reason for your visit? _____

Previous dentist's name _____

Address _____

How often do you...

What was the date of your last...

brush your teeth? _____

visit? _____

floss your teeth? _____

hygiene visit? _____

have dental exams? _____

X-Ray? _____

What other aids do you use (electric toothbrush, toothpick, etc.)? _____

Do you have any dental problems?

Yes No Explain. _____

Are any of your teeth sensitive to...

hot or cold? Y N

sweets? Y N

biting or pressure? Y N

Have you ever noticed any mouth odors or bad taste? Y N

Do you frequently get cold sores, blisters or any lesions? Y N

Do your gums bleed or hurt? Y N

Have your parents experienced gum disease or tooth loss? Y N

Have you noticed any loose teeth or change in your bite? Y N

Does food tend to become caught between your teeth? Y N

Do You...

clench or grind teeth (awake or asleep)? Y N

have tired jaws (especially in the a.m.)? Y N

bite your lips or cheeks regularly? Y N

hold foreign objects with your teeth (pencils, pens, nails, fingernails, pipe)? Y N

mouth breathe while asleep or awake? Y N

snore? Y N

Have you ever experienced...

clicking or popping of the jaw? Y N

pain (joint, ear or side of face)? Y N

difficulty opening or closing the mouth? Y N

frequent headaches, neck aches, or shoulder aches? Y N

any pain or soreness in the muscles of your face or around the ears? Y N

Have you ever had...

orthodontic treatment? Y N

oral surgery? Y N

teeth removed? Y N

If so, have they been replaced? Y N

fixed bridge? Y N

removable partial? Y N

complete denture? Y N

implants? Y N

If so, are you happy with replacements? Y N

periodontal treatment? Y N

your teeth ground or the bite adjusted? Y N

gum surgery? Y N

if so, when? _____

by whom? _____

a serious injury to the mouth or head? Y N

If so, please describe (include cause). _____

Do you like the appearance of your teeth and smile? Y N

Do you like the color of your teeth? Y N

Would you like your teeth straightened? Y N

What would you like to change most in the appearance of your teeth? _____

Do you feel anxiety about having dental treatment? Y N

Have you ever had an upsetting dental experience? Y N

If yes, please describe. _____

How did you overcome your anxiety? _____

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

Doctor comments:
