**DENTAL HISTORY**

What is the reason for your visit today? _____

Previous Dentist's Name _____ Address _____

Date of Last Visit _____ Last Hygiene Visit _____ Last X-Rays _____

How often do you have dental examinations? _____

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

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

Do you have any dental problems? Yes☐ No☐

If yes, please describe _____

**Are any of your teeth sensitive to:**

| | | |
|---|---|---|
| Hot or Cold? | Yes ☐ | No ☐ |
| Sweets? | Yes ☐ | No ☐ |
| Biting or pressure? | Yes ☐ | No ☐ |
| Have you ever 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 ☐ |
| 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 between your teeth? | Yes ☐ | No ☐ |

**Do you:**

| | | |
|---|---|---|
| Clench or grind your teeth while awake or asleep? | Yes ☐ | No ☐ |
| Have tired jaws, especially in the morning? | Yes ☐ | No ☐ |
| Bite your lips or cheeks regularly? | Yes ☐ | No ☐ |
| Hold foreign objects with your teeth? (pencils, pins, nails, fingernails, pipe) | Yes ☐ | No ☐ |
| Mouth breath while asleep or awake? | Yes ☐ | No ☐ |
| Snore? | 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 the mouth? | Yes ☐ | No ☐ |
| Frequent headaches, neckaches, or shoulder aches? | Yes ☐ | No ☐ |
| Any pain or soreness in the muscles of your face or around the ears? | 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 ☐ |
| Implants? | Yes ☐ | No ☐ |
| Are you happy with the replacement? | 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 describe. Include cause. _____

| | | |
|---|---|---|
| Do you like the appearance of your teeth; your smile? | Yes ☐ | No ☐ |
| Do you like the color of your teeth? | Yes ☐ | No ☐ |
| Are your teeth as straight as you would like? | Yes ☐ | No ☐ |

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

| | | |
|---|---|---|
| Do you feel anxiety about having dental treatment? | Yes ☐ | No ☐ |
| Have you ever had an upsetting dental experience? | Yes ☐ | No ☐ |

If yes, please describe, _____

How did you overcome your anxiety? _____

**Is there anything else about having dental treatment that you would like us to know, please describe.** _____

DR. COMMENTS:

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

Patient Signature _____ Date _____
(PARENT/GUARDIAN OF A MINOR)

Doctor Signature _____ Date _____

**DENTAL HISTORY** **NAME**_____ **#**_____