DENTAL HISTORY

Name: _____

What is the main reason for your visit today? _____
When was your last dental exam? _____
How do you feel about the condition of your mouth? _____
If not, what would you improve? _____
Does the thought of dental care make you nervous? _____ Yes _____ No
If yes, what is the most bothersome? _____
Previous Dentist's Name: _____
Why did you leave your former dentist? _____
How often do you?
A. Have dental examinations and cleaning? _____
B. Brush your teeth? _____
C. Floss your teeth? _____
What other dental aids do you use? (Interplak, toothpick, etc.) _____

Are your teeth sensitive to:
Hot or Cold? __ Yes __ No
Sweets? __ Yes __ No
Biting or Chewing __ Yes __ No
Do you ever have mouth Odor or bad taste? __ Yes __ No
Do you tend to get cold Sores or fever blisters? __ Yes __ No

Do your gums bleed or hurt:
Have your parents experienced Gum disease or tooth lose? __ Yes __ No
Have you noticed any loose Teeth or change in your bite? __ Yes __ No
Does food tend to get caught Between your teeth? __ Yes __ No
If yes, Where? _____

Do You:
Clench or grind your teeth? __ Yes __ No
While asleep or awake? _____
Bite/chew your lips or cheeks? __ Yes __ No
Hold foreign objects with your Teeth? (pen, fingernails, pipe) __ Yes __ No

Mouth breathe while asleep Or awake? __ Yes __ No
Smoke/chew tobacco? __ Yes __ No

Have you ever had:
Orthodontic treatment? __ Yes __ No
Oral surgery? __ Yes __ No
Periodontal treatment? __ Yes __ No
Bite adjustment? __ Yes __ No
Serious injury to the Mouth or head? __ Yes __ No
If yes, please describe: _____

Have you ever experienced:
Clicking or popping of your jaw? __ Yes __ No
Pain? (joint, ear, face) __ Yes __ No
Difficulty in chewing? __ Yes __ No
Headaches/neck aches? __ Yes __ No
Are you satisfied with the Appearance of your teeth? __ Yes __ No
Do you expect to keep your Teeth all of your life? __ Yes __ No
Have you ever had an upsetting Dental experiences? __ Yes __ No
If so, please describe
_____

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

If yes, Please explain: _____
_____