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 experience? ◯ 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: