# DENTAL HISTORY

**Patient Name** _____ **Date of Birth**_____

**Medical Alert, please specify**_____

**What is the reason for your visit today?** _____

**If you were able to change anything about your smile, what would you change?**_____

**Date of last Dental Visit**_____ **Last Dental Cleaning**_____ **Last Full Mouth X-rays**_____
What was done at your last dental visit? _____

**Previous Dentist/Dental Group Name**_____
Address_____State_____ Zip_____ Phone : (____)_____

**How often do you have dental examinations?** _____
How often do you brush your teeth? _____ How often do you floss? _____

What dental aids do you use? (Hydro floss, Electric Toothbrush, Toothpick) : _____

Do you have dental problems? **Yes/No** If **yes**, please describe: _____

**Is there anything else about having dental treatment that you would like us to know about? If so, please describe below:**
_____

**Please circle the correct response:**

Are any of your teeth sensitive to:

| | | |
|---|---|---|
| hot/cold | yes | no |
| sweets | yes | no |
| Biting or chewing | yes | no |
| Mouth odor/bad breath | yes | no |
| Do you frequently get cold sores/blisters/lesions? | yes | no |
| Do your gums bleed or hurt? | yes | no |
| Have your parents had gum disease or tooth loss? | yes | no |
| Have you noticed any loose teeth or change in 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 |
| Do you bite your lips or cheeks regularly | yes | no |
| Do you hold foreign objects in your teeth? | yes | no |
| Do you bite your nails | yes | no |
| Do you mouth breathe while awake or sleeping? | yes | no |
| Do you smoke or chew tobacco? | yes | no |
| Have you ever had orthodontic treatment? | yes | no |

**Have you ever had:**

| | | |
|---|---|---|
| Oral surgery? | yes | no |
| Periodontal treatment? | yes | no |
| Your bite adjusted? | yes | no |
| A serious head or mouth injury? | yes | no |
| If so, please describe: | | |
| _____ | | |
| Experienced clicking or popping? | yes | no |
| Experienced pain (joint, ear, face)? | yes | no |
| Difficulty chewing? | yes | no |
| Headaches or neckaches | yes | no |
| Shoulder aches or muscle aches? | yes | no |
| Are you satisfied with your teeth's appearance? | yes | no |
| Do you feel nervous about dental treatment? | yes | no |
| If so, what is your biggest concern? | | |
| _____ | | |
| Have you ever had an upsetting dental experience? | yes | no |
| If yes, please describe: _____ | | |

**Doctor's Notes:**