# Dental History

_____ _____
Patient Name Preferred

What is the reason for your visit today?

_____

Date of Last Dental Visit_____Last Dental Cleaning_____Last Full Mouth X-rays_____

What was done at your last dental visit?_____

Previous Dentist's Name_____Phone Number_____
Address_____

Reason for leaving previous dentist_____

**How often do you have dental examinations?_____**
How often do you brush your teeth?_____How often do your floss?_____
What other dental aids do you use?(Toothpick, powered toothbrush, waterpic, etc)_____

**Do you have any dental problems now? Yes_____ No_____**
If yes, please
describe:_____
_____

**Are any of your teeth sensitive to:**
Hot or cold? Yes___No___
Sweets? Yes___No___
Biting or Chewing? Yes___No___
Have you noticed any mouth odors or bad tastes?
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? Yes___No___

Does food tend to become caught in
between your teeth? Yes___No___
If yes, where?_____
(upper right, lower right, etc.)

**Have you ever had:**
Orthodontic treatment? Yes___No___
Oral Surgery? Yes___No___
Periodontal (gum) treatment? Yes___No___
Bite adjustment for grinding? Yes___No___
Bite plate or mouth guard? Yes___No___
Serious injury to mouth or head Yes___No___
If so, describe, including cause_____
_____

**Have you experienced:**
Clicking or popping of the jaw? Yes___No___
Pain? (joint, ear, side of face) Yes___ No___
Difficulty in opening or closing the mouth?
Yes___No___
Headaches, neck aches or shoulder aches?
Yes___No___
Sore muscles (neck, shoulder)? Yes___No___

**Do you:**
Clench or grind teeth while awake or asleep?
Yes___No___
Mouth breathe while awake or asleep?
Yes___No___
Have tired jaws, especially in the morning?
Yes___No___
Smoke/chew tobacco?
Yes___No___

**Are you satisfied with your teeth's appearance?**
Yes___No___

Would you like to keep all of your teeth for lifetime?
Yes___No___
How would you rate your current dental health?
(1 – 10) _____
If you could change your smile in any way, including whiter teeth,
what would you want to change?_____
_____

Do you feel nervous about dental treatment? If so what is your biggest concern?_____

Have you ever had an upsetting dental experience?_____

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