DENTAL HISTORY

What is the reason for your visit today ____
Date of Last Dental Visit ____________________
Date of Last Dental Cleaning ________________
Last full mouth X-Ray ______________________
What was done at your last dental visit?____

PREVIOUS DENTIST'S NAME		
ADDRESS		
CITY	STATE	ZIPCODE
PHONE #		

How often do you have dental examinations?____
How often do you brush your teeth?____
How often do you floss?____
Have you ever used or are currently using a topical fluoride or rinse?.. YES | NO
What other dental aids do you use? (Interplax, toothpick, 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/bad tastes?..................... YES | NO
Do you frequently get cold sores/blisters/other?..................... 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 get caught between your teeth?........................ YES | NO
If yes, where ___________________________________

HAVE YOU EVER HAD

Orthodontic Treatment? .... YES | NO
Oral surgery? .... YES | NO
Periodontal Treatment?.. YES | NO
Your teeth ground or bite adjusted? .... YES | NO
A bite plate or mouth guard? .... YES | NO
A serious injury to the mouth or head? .... YES | NO
If yes, please describe, including cause
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DO YOU

Clench or grind your teeth while awake or asleep? .... YES | NO
Bite your lips or cheeks regularly? .... YES | NO
Hold foreign objects with your teeth? (pens, pencils, etc.).... YES | NO
Mouth breathe while you are awake or asleep? .... YES | NO
Have tired jaws, especially in the morning? .... YES | NO
Snore or have any other sleep disorders? .... YES | NO
Smoke/chew tobacco or use other tobacco products? ..... YES | NO

HAVE YOU EVER 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
Difficulty in chewing on either side of the mouth? .... YES | NO
Headaches, neckaches or shoulder aches? .... YES | NO
Sore muscles? (neck, shoulders) .... YES | NO

Are you satisfied with you teeth's appearance?.. YES | NO
Would you like to keep your teeth all your life?... YES | NO

Do you feel nervous about your 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 ____
Have you ever been told to take a pre-medication prior to dental treatment?.............. YES | NO

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

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