# DENTAL HISTORY

**Patient Name:** ______________________________ **Medical Alert:** ______________________________

***Welcome!*** *So that we may provide you with the best possible care*
*please complete this medical/dental history form. All information is completely confidental.*

**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 ______________________________

Address ______________________________
Street City State Zip Code

Telephone ______________________________

**How often do you have dental examinations?** ______________________________

How often do you brush your teeth? _______________ How often do you floss? _______________

What other dental aids do you use? (Interplak, toothpick, etc.) ______________________________

**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 you frequently get cold sores, blisters or any other oral lesions? 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 tend to become caught in between your teeth? Yes No
If yes, where? _______________

**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? (pencils, pipe, pins, nails, fingernails) Yes No
Mouth breathe while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No
Snore or have any other sleeping disorders? Yes No
Smoke/chew tobacco or use other tobacco products? Yes No

**Have you ever had orthodontic treatment?** Yes No
How long ago? Yes No
Have you had movement in your teeth since? Yes No

**Have you ever had periodontal treatment?** Yes No
If so, when?_______________
If so, what kind?_______________

**Have you ever had:**

Oral Surgery? Yes No
Your teeth ground or the bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No
If so, please 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
Difficulty in chewing on either side of the mouth? Yes No
Headaches, neckaches, or shoulder aches? Yes No
Sore muscles (neck, shoulders)? Yes No

**Do you wear dentures/partials?** Yes No
Do they fit well? Yes No
Do you have trouble chewing? Yes No
Do you use adhesive? Yes No

**Are you satisfied with your teeths appearance?** Yes No
Would you like to keep all of your teeth all of your life? Yes No
Do you feel nervous about having dental treatment? ______________________________
If so, what is your biggest concern? ______________________________
Have you ever had an upsetting dental experience? Yes No
If yes, please describe ______________________________
If no, what don't you like? ______________________________

**Have you whitened your teeth before?** Yes No
If yes, how? ______________________________

*What would you change about your smile if you could?* ______________________________