

DENTAL HISTORY

Patient Name _____	Medical Alert _____
--------------------	---------------------

Do you have any dental concerns at this time? Yes / No

If yes, please describe: _____

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# _____

How often do you brush your teeth? _____ **How often do you floss or clean between your teeth?** _____

What other dental aids do you use? (Sonicare, Waterpick, Braun) _____

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 any change in your bite? Yes No

Does food tend to become caught
between teeth? Yes No

If yes, where? _____

Do you:

Frequently get cold sores, blisters,
or other oral lesions? Yes No

Clench or grind your teeth? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? Yes No

Have tired jaws, especially in AM? Yes No

Smoke/chew tobacco? Yes No

How often? _____

Snore or have sleep apnea? Yes No

Chew more on one side of your
mouth? Which side? _____ Yes No

Have you ever had:

Orthodontic treatment (braces) Yes No

Oral surgery or teeth extracted Yes No

Teeth replaced with implant Yes No

Teeth replaced with bridge Yes No

Periodontal (gum) treatment Yes No

If yes, describe _____

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain associated with your jaw?
(Jaw Joint, Ear, Side of face) Yes No

Difficulty in:

Opening or closing the mouth? Yes No

Chewing on either side of mouth? Yes No

Headaches, How often _____ Yes No

Sore muscles (neck, shoulders)? Yes No

**Are you satisfied with the
appearance of your teeth?** Yes No

**Do you expect to keep your teeth
forever?** Yes No

**Do you feel nervous about dental
treatment?** Yes No

If so, what concerns you _____

**Have you ever had an upsetting dental
experience?** Yes No

If yes, please describe _____

Are there any questions about dental health that have not been adequately explained to you? Yes No

If yes, please describe _____