DENTAL HISTORY

Name: _____ **Date:** _____

How are you feeling today? _____
Do you have any dental problems now? _____
Are you in Dental Pain? _____
What is the reason for your dental visit today? _____
Are you nervous about having dental treatment? ____What are your concerns? _____

Previous Dentist name: _____
Address: _____
Phone Number: _____ Last Cleaning:_____
Date of your last dental visit: _____ Last full mouth set of Xrays: _____

How frequently do you visit the Dentist: _____
How frequently do you brush? _____ How frequently do you floss?_____
What dental aids do you use (Tooth Picks, WaterPik, Mouthwash, etc.)?_____

Are your teeth sensitive to: Hot Cold Sweets Biting/Chewing Brushing Acidic Foods
Have you noticed any mouth odor or bad tastes? _____
Do you frequently get cold sores, blisters, or any other oral lesions? _____
Do your gums bleed or hurt? _____
Does food tend to get caught in between your teeth? _____ Where? _____

Do you:
- Clench or Grind your teeth while awake or asleep? _____
- Bite your lips or cheeks regularly? Accidentally or Habitually? _____
- Hold foreign objects with your teeth (Pens, Pins, Fingernails)? _____
- Breathe with your mouth while awake or sleep? _____
- Have tired jaws, especially in the morning? _____
- Smoke or Chew tobacco? _____
- Snore? _____

Consume the following: Soda/Juice Sweets Coffee/Tea Chewing Gum

Have you ever had: (circle what applies)
Orthodontic treatment
Periodontal (Gum) treatment
Serious injury to mouth or head
Oral Surgery (teeth removed)
Mouth Guard or Nightguard
Root Canal Treatment

Does your jaw: (circle what applies)
Click or pop
Get Sore
Become painful
Have difficulty opening or closing
Have difficulty chewing

Are you satisfied with your teeth's appearance? _____
Have you had an upsetting dental experience? _____
Is there anything else about having dental treatment that you would like us to know?