# DENTAL HISTORY

## DENTAL HISTORY

Patient's First Name *

Patient's Last Name *

Patient's No.

**DENTAL HISTORY**

What is the reason for your visit today?

Previous Dentist's Name

Address

Date of Last Visit

MM/dd/yyyy

Last Hygiene Visit

MM/dd/yyyy

Last X-Rays

MM/dd/yyyy

How often do you have dental examinations?

How often do you brush your teeth?

How often do you floss?

What other aids do you use? (Electric toothbrush, toothpick, etc.)

Do you have any dental problems?

○ Yes ○ No

**Are any of your teeth sensitive to:**

Hot or Cold?

○ Yes ○ No

Sweets?

○ Yes ○ No

Biting or pressure?

○ Yes ○ No

**Do your gums bleed or hurt?**

○ Yes ○ No

Have your parents experienced gum disease or tooth loss?

○ Yes ○ No

**Do you:**

Clench or grind your teeth while awake or asleep?

○ Yes ○ No

Have tired jaws, especially in the morning?

○ Yes ○ No

Have you ever noticed any mouth odors or bad taste?

○ Yes ○ No

Do you frequently get cold sores, blisters or any lesions?

○ Yes ○ No

Have you noticed any loose teeth or change in your bite?

○ Yes ○ No

Does food tend to become caught between your teeth?

○ Yes ○ No

Hold foreign objects with your teeth?

○ Yes ○ No

(pencils, pins, nails, fingernails, pipe)

Mouth breather while asleep or awake?

○ Yes ○ No

Bite your lips or cheeks regularly?

○ Yes ○ No

Snore?

○ Yes ○ No

**Have you ever experienced**

Clicking or popping of the jaw?

○ Yes ○ No

Frequent headaches, neckaches, or shoulder aches?

○ Yes ○ No

Pain?

○ Yes ○ No

(Joint, ear, side of face)

Any pain or soreness in the muscles of your face or around the ears?

○ Yes ○ No

Difficulty opening or closing the mouth?

○ Yes ○ No

**Have you ever had**

Orthodontic treatment?

○ Yes ○ No

Gum Surgery?

○ Yes ○ No

Oral surgery?

○ Yes ○ No

Your teeth ground or the bite adjusted?

○ Yes ○ No

Teeth removed?

○ Yes ○ No

A serious injury to the mouth or head?

○ Yes ○ No

Fixed Bridge?

○ Yes ○ No

Do you like the appearance of your teeth; your smile?

○ Yes ○ No

Removable Partial?

○ Yes ○ No

Do you like the color of your teeth?

○ Yes ○ No

Complete Denture?

○ Yes ○ No

Are your teeth as straight as you would like?

○ Yes ○ No

Implants?

○ Yes ○ No

What would you like to change most in the appearance of your teeth?

Are you happy with the replacement?

○ Yes ○ No

Periodontal Treatment?

○ Yes ○ No

Do you feel anxiety about having dental treatment?

○ Yes ○ No

Have you ever had an upsetting dental experience?

○ Yes ○ No

How did you overcome your anxiety?

**Is there anything else about having dental treatment that you would like us to know, please describ**e

DR. COMMENTS

**I consent to the doctor's exam and necessary diagnostics for treatment including x-rays.**

Patient Signature *

Date

10/16/2024

Doctor Signature

Date

10/16/2024