

Dental History

Patient Name: (Please Print) _____ Date: _____

Please answer the following questions to the best of your ability:

Date of most recent dental exam / cleanings _____ Any x-rays taken at this time? _____

Date of most recent dental treatment _____ Treatment performed _____

IMMEDIATE DENTAL CONCERNS? _____

Please mark YES or NO to the following questions:

YES NO

- | | | |
|--------------------------|--------------------------|-------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Do your gums bleed when brushing, flossing or eating? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have difficulty brushing or flossing an area? Does food collect between your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a bad taste or odor in your mouth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any loose teeth, or have any teeth moved or shifted within the past two years? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you or have you ever smoked? (packs/day _____) When did you quit? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been diagnosed or treated for periodontal disease? Any family history? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you floss, use a water jet device, interdental stimulator, or proxy brush? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have toothaches, sore teeth or dental pain? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are your teeth sensitive to hot, cold, sweets, biting, or touch? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any broken teeth, missing fillings, or root canals? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a dry mouth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink fluoridated water or take fluoride supplements? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had cavities diagnosed or treated within the past two years? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you clench or grind your teeth? Are you awake or asleep when it occurs? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have soreness or pain in your jaw, ear, or side of your face? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you get frequent headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your jaw ever pop, click, lock, or become fatigued or tired? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have difficulty opening, closing, or chewing certain types of foods, i.e. gum or bagels? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your teeth come together unevenly or do you hit one tooth before the others when you bite? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear a splint, night guard or had an injury to the head/neck including an auto accident? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have your teeth changed in the last 5 years? Do they appear shorter, |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you dissatisfied with the appearance of your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you dislike the color of your teeth or have noticeable spots or stains? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have existing crowns or dental work, which you consider "ugly"? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have chips, spaces, crowded or crooked teeth that bother you? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you self-conscious of your teeth or smile or has anyone suggested you change your smile? |
| <input type="checkbox"/> | <input type="checkbox"/> | Would you like to improve your smile? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had complications from past dental treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you experienced any complications or reactions from local anesthetic? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had teeth extracted? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you ever have braces or orthodontic treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any lumps, sores, or growths in your mouth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does dental treatment cause you much worry or concern? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had an unpleasant dental experience in the past? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you think your teeth are affecting your general health? |

Patient Signature: _____ Date: _____

If you have a partial or denture, please complete the Denture / Partial History Form.