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

Denture / Partial History

Patient Name: (Please Print) _____ **Date:** _____

Denture / Partial History

If you are wearing a partial or complete artificial denture, please complete the following questions by marking yes or no.

YES	NO	
☐	☐	Do you have a denture or partial? Please indicate what you have on the upper _____ (denture or partial)
		Please indicate what you have on the lower _____ (denture or partial)
☐	☐	Has your present denture/partial been relined? When? _____
☐	☐	Is your present denture a problem? Please describe _____ _____
☐	☐	Are you satisfied with the appearance?
☐	☐	Are you satisfied with the comfort?
☐	☐	Are you satisfied with the chewing ability?
		When did you receive your first partial or complete denture? _____
		How long have you worn your present partial or denture? _____