DENTAL HISTORY

What is the reason for your visit today?_____
Date of Last Dental Visit_____Last Dental Cleaning_____Last Full Mouth X-Rays_____
General Dentist's Name:_____

Do you have any dental problems now? Yes_____ No_____
If yes, please describe_____

Are your teeth sensitive to:		
Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or chewing?	Yes	No
Continuous mouth odors/bad taste?	Yes	No
Do you frequently get cold sores, blisters or other oral lesions?	Yes	No

Have you ever had:		
Dental Implants?	Yes	No
Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Serious injury to the mouth or head?	Yes	No
A bite plate or mouth guard?	Yes	No
Your teeth ground or bite adjusted?	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 Change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where?_____

Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint,ear,side of face)	Yes	No
Difficulty opening or closing mouth?	Yes	No
Difficulty chewing on either side of mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No

Do you:		
Clench/grind teeth while awake/asleep?	Yes	No
Bite lips/cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils,pens,pipe,nails,fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Are you satisfied with the appearance of your teeth?	Yes	No
Would you like to keep your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern? _____		
Have you ever had an upsetting dental experience?	Yes	No

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe_____

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature_____Date_____

History Review

Doctor Signature_____Date_____