DENTAL HISTORY

NAME____________________________DATE_________________________

YES NO

What is the purpose of your visit? _____________________________

____

____ ____ Are any or all of your teeth sensitive to: Heat____Cold___________
Sweets_______Biting or pressure____

____ ____ Do you feel any teeth that are loose?

____ ____ Have you noticed any tenderness or swelling in your gums?

____ ____ Do you avoid either side while chewing or brushing?
Which side? __________ Why? _________

____ ____ Do your gums bleed when you brush? Floss? Chew? (circle)

____ ____ Have you had periodontal treatments?

____ ____ Are you aware that you may be clenching or grinding your teeth?
Day or Night (circle)

____ ____ Do your jaws ever feel tired, especially in the morning?

____ ____ Have you ever had your mouth stuck open or closed? (circle)

____ ____ Do you have pain in front or above your ears? Which side? _____________

____ ____ Do you seem to have frequent headaches, neck aches or shoulder aches?
(circle)

____ ____ Do you have popping or clicking noises in your ears when you bite?

____ ____ Do you seem to strike some teeth before others when you bite?

____ ____ Do you have all or most of your natural teeth?

____ ____ Have missing teeth been replaced?

____ ____ If not replaced are you concerned about the possible outcome?

____ ____ Have any of your family lost all their teeth?

____ ____ Have you ever had braces?

____ ____ Have you had wisdom teeth removed?

YES NO

____ ____ Have you had a complete dental examination, including a complete series of dental x-rays (16-18 films) or whole mouth x-ray within the last 3 years?

____ ____ Have you had your teeth cleaned and examined regularly?
How often? __________ Date of last cleaning? ____________

____ ____ Have you ever been instructed regarding proper home care of your teeth?
How often do you clean your teeth? _____________

____ ____ Have you ever been instructed regarding proper diet?

____ ____ Do you have areas where food gets trapped? Which side? _________

____ ____ Do you have bad breath? How often? ___________

____ ____ Do you use dental floss or tape? How often? ____________
What type of brush? Hard Medium Soft Electric (circle)
What other cleaning aids, rinses or devices do you use? ________________

____ ____ Are you familiar with the term “bacterial plaque”?
In your estimation, which term best describes periodontal disease?
____Rampant decay _____Sore gums ____Bleeding gums____Bone loss

____ ____ Do you have any metal allergies?

When was your last dental visit? _______________

What was its purpose? ___________________

Please explain how you feel about your teeth ________________________
____

How do feel about going to the dentist? ____________________________

____ ____ Have you ever had an unpleasant dental experience?
Please list other questions and concerns you have about your mouth or oral health ____

Signature of Patient ________________________________

Signature of Dentist ________________________________