DENTAL HISTORY

Patient Name _____

What is the reason for your visit today? _____

_____

Date of last dental visit? _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

Previous Dentist Name? _____

Address _____

What was done at your last visit?_____

Do you pre-medicate for dental treatment? Yes _____

How often do you have dental exams? _____

How often do you brush your teeth? _____ Floss? _____

Have you ever used or are currently using topical fluoride? Yes _____

What other dental aides do you use? Waterpik, toothpick, etc _____

Do you currently have any dental problems? IF yes please describe _____

Please circle all that apply

Are your teeth sensitive to hot or cold?.....Yes

Are your teeth sensitive to Sweets? ..... Yes

Sensitive to Biting or Chewing ..... Yes

Have you noticed any mouth odors or bad tastes? .... Yes

Do you often get cold sores, fever blisters lesions .....Yes

Do your gums bleed or hurt? .....Yes.

Have your parent's had gum disease or tooth loss? ...Yes

Have you noticed loose teeth change in bite? .....Yes

Does food tend to get caught between teeth? .....Yes

Do You:

Clench of grind teeth while awake or sleeping? ..... Yes

Bite your lips or cheeks regularly? .....Yes

Hold objects with your teeth, pen, pipe, etc? .....Yes

Mouth breathe while awake or asleep? .....Yes

Snore or have any sleep disorders? .....Yes

Smoke/chew tobacco or use tobacco products? .....Yes

Have you ever had:

Othodontic treatment ..... Yes

Oral Surgery .....Yes

Periodontal Treatment .....Yes

Your teeth ground or the bite adjusted? .....Yes

A bite plate or mouth guard? .....Yes

Serious injury to mouth or head? .....Yes

Have you experienced?

Clicking or popping of jaw? ..... Yes

Pain, joint, ear, side of face? .....Yes

Difficulty opening closing mouth?..... Yes

Difficulty chewing on either side of mouth? .... Yes

Headaches, neckaches, shoulder aches? ..... Yes

Sore muscles , neck, shoulders? ..... Yes

Tired jaws esp. in morning..... Yes

Are you satisfied with your teeth's appearance Yes

Would you like to replace silver fillings? ...Yes

Do you feel nervous to have dental treatment? .....Yes Describe _____

Have you ever had an upsetting dental experience? .....Yes Describe _____