DENTAL HISTORY

NAME_____**D.O.B.**_____

PHONE # (HOME)_____**(CELL)**_____**(WORK)**_____

1. Reason for your visit? _____
2. When was your last dental exam? _____
3. How often do you brush your teeth? _____
4. What texture brush do you use? ☐Soft ☐Medium ☐Hard

	YES	NO
5. Do your gums bleed while brushing or flossing?	☐	☐
6. Do you feel pain in any of your teeth while brushing or flossing?	☐	☐
7. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	☐	☐
8. Have you noticed any loosening of your teeth?	☐	☐
9. Does food tend to become caught between your teeth?	☐	☐
10. Do you have any sores or lumps in or near your mouth?	☐	☐
11. Have you ever experienced any of the following problems in your jaw?		
A. Clicking	☐	☐
B. Pain (joint, ear, or side of face)?	☐	☐
C. Difficulty in opening or closing?	☐	☐
D. Difficulty in chewing?	☐	☐
12. Do you have sinus pain or pressure?	☐	☐
13. Do you snore?	☐	☐
14. Have you had any head, neck or jaw injuries?	☐	☐
15. Do you have frequent headaches?	☐	☐
16. Do you clench or grind your teeth while awake or asleep?	☐	☐
17. Do you bite your lips or cheeks frequently?	☐	☐
18. Do you suffer from dry mouth?	☐	☐
19. Have you had any of the following?		
A. Orthodontic Treatment (braces)?	☐	☐
B. Oral Surgery?	☐	☐
C. Gum treatment?	☐	☐
D. Your bite adjusted or teeth ground?	☐	☐
E. Worn a bite plane or other oral appliance?	☐	☐
20. Are you satisfied with the appearance of your teeth?	☐	☐
If no, please explain: _____		
21. Have you ever had an upsetting experience in the dental office?	☐	☐
22. Is there anything about having dental treatment that bothers you?	☐	☐
If yes, please explain: _____		