Dental History

Reason for today's visit _____
Are you in pain? □ Yes □ No

If so, please describe _____
Do you have any dental problems now? □ Yes □ No

If so, please describe _____
Have you ever had trouble with a previous dental treatment? □ Yes □ No

If so, please describe _____

Level of anxiety about seeing a dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam _____ Date of last cleaning _____ Date of last full mouth x-rays _____
Procedure(s) done at last dental visit _____
Previous dentist's name _____
City _____ State _____ Phone_____
Why are you changing dentists? _____

How often do you have dental examinations? _____How often do you floss? _____
How often do you brush your teeth? _____ What type of bristles do you use? □ Hard □ Medium □ Soft
What other dental aids do you use? (electric toothbrush, toothpick, etc.) _____

Do you require antibiotics before dental treatment?	□ Yes	□ No	Do you have frequent headaches?	□ Yes	□ No
Do your gums ever bleed?	□ Yes	□ No	Do you clench or grind your teeth?	□ Yes	□ No
Have you noticed any mouth odors or bad tastes?	□ Yes	□ No	Are your teeth sensitive to heat/cold?	□ Yes	□ No
Do you bite your lips or cheeks frequently?	□ Yes	□ No	Do you still have your wisdom teeth?	□ Yes	□ No

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Have you ever had:

Periodontal Disease / gum treatment	□ Yes	□ No	Discomfort in your jaw joint (TMJ/TMD)	□ Yes	□ No
Orthodontics treatment	□ Yes	□ No	Your teeth ground or bite adjusted	□ Yes	□ No
Oral surgery	□ Yes	□ No	Serious injury to the mouth or head	□ Yes	□ No
A bite plate or mouth guard	□ Yes	□ No			

If yes to any of the previous questions, please describe _____

_____

Is there anything else about your past dental treatment(s) that you would like us to know? _____

_____

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