

DENTAL HISTORY

Name: _____

- 1) Who may we thank for referring you today? _____
- 2) What is the reason for your visit today? _____
- 3) When was your last dental visit? _____
- 4) When was your last dental cleaning? _____
- 5) When was your last Full Mouth X-Rays? _____
- 6) What is your previous dentist's name? _____ Phone # _____
- 7) How often do you have dental examinations? _____
- 8) How often do you brush your teeth? _____ Floss? _____
- 9) What other dental aids do you use (Water Pik, Interplak, Toothpick etc.)? _____
- 10) Do you have any dental/tooth problems now? _____ Describe _____
- 11) Are your teeth sensitive to hot/cold or sweets or chewing/biting? _____
- 12) Do you have Halitosis (Mouth Odors/Bad Breath)? _____
- 13) Do you have a bad taste in your mouth? _____
- 14) Do you get frequent cold (canker) sores or blisters? _____
- 15) Do your gums bleed when you brush or floss? _____
- 16) What brand/type toothpaste do you use? _____ Mouthwash _____
- 17) Have any of your family members experienced gum disease or tooth loss? _____
- 18) Have you noticed any loose teeth or change in your bite? _____
- 19) Does food tend to get caught between your teeth? _____
- 20) Do you clench or grind your teeth? _____ Do you bite your lips or cheeks _____
- 21) Do you hold foreign objects with your teeth (pencils)? _____ Do you bite your nails? _____
- 22) Are you a mouth breather when awake or asleep? _____
- 23) Have you experienced popping or clicking of the jaw? _____
- 24) Have you ever had pain in your jaws? _____

25) Have you ever had difficulty opening or closing your mouth? _____

26) Do you smoke? _____ How much? _____ Do you use snuff (chew tobacco) _____

27) Do you snore when sleeping? _____ Do you awake refreshed? _____

28) Has anyone reported that you choke or gasp for air while asleep? _____

29) Have you ever had Orthodontic (Braces) treatment? _____ Periodontal (Gum) treatment? _____

30) Have you ever had a serious injury to mouth or head? _____

31) Do you wear a partial denture/removable bridge? _____ If yes, when was it made? _____

32) Do you feel nervous about having dental treatment? _____

33) If so, what is your biggest concern? _____

34) Have you had an upsetting dental experience? _____ If so, describe? _____

35) When you look in the mirror, do you like the way your teeth look? _____

36) If no, what don't you like? _____

37) Do you think your teeth are white enough? _____ Are your teeth straight? _____

38) Are any of your teeth too big or too small? _____ Are you interested in Cosmetic Dentistry? _____

Signature _____ Date _____