

DENTAL HISTORY

What is the Reason for Your Visit Today? _____

Previous Dentist's Name _____ Address _____

Date of Last Visit _____ Last Hygiene (Cleaning) Visit _____ Last X-Rays _____

How often do you have dental examinations? _____

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

What other aids do you use? (Electric toothbrush, toothpick, etc) _____

<p>Are any of your teeth sensitive to:</p> <p>Hot or Cold? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sweets? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Biting or pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever noticed any mouth odors or bad taste? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you frequently get cold sores, blisters or any lesions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do your gums bleed or hurt? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have your parents experienced gum disease or tooth loss? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you noticed any loose teeth or change in your bite? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does food tend to become caught between your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you:</p> <p>Clench or grind your teeth while awake or asleep? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have tired jaws, especially in the morning? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bite your lips or cheeks regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hold foreign objects with your teeth? (pencils, pins, nails, fingernails, pipe) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mouth breathe while asleep or awake? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Snore? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you use a CPAP machine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever experienced:</p> <p>Clicking or popping of the jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain? (Joint, ear, side of face) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty opening or closing the mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent headaches, neck aches, or shoulder aches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any pain or soreness in the muscles of your face or around the ears? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Have you ever had:</p> <p>Orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Oral Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Teeth removed? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, have they been replaced? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you happy with their replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Removable Partial? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Complete Denture? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fixed Bridge? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Implants? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Periodontal Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gum Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when? _____ By whom? _____</p> <p>Your teeth ground or the bite adjusted? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>A serious injury to the head or jaws? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please describe. Include cause _____</p> <p>Do you like the appearance of your teeth / smile? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you like the color of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are your teeth as straight as you would like? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What would you like to change most in the appearance of your teeth? _____ _____</p> <p>Do you feel anxiety about having dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever had an upsetting dental experience? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe, _____ How did you overcome your anxiety? _____</p>
--	--

Is there anything else about having dental treatment that you would like us to know? Please describe _____

Do you have any other dental problems? Yes No
If yes, please describe _____

I consent to the doctor's examination and necessary diagnostics for treatment including X-rays

Patient Signature _____ Date _____
(PARENT/GUARDIAN OF A MINOR)

Reviewed by _____ Date _____