# Dental History

Patient First Name: Patient Last Name:

Home Phone: Reason for your visit?

Previous dentist'sname:

Previous dentist's address:

**How often do you...**
- brush your teeth?
- floss your teeth?
- have dental exams?

**What was the date of your last…**
- visit?
- hygiene visit?
- X-Ray?

What other aids do you use (electric toothbrush, toothpick, etc.)?

Do you have any dental problems? Yes No

If yes, explain:

***Personal History*** **YES NO**

1. Have you ever had orthodontic treatment?
2. Have you ever had oral surgery?
3. Have you ever had any teeth removed?
   If so, have they been replaced? Yes No
4. Have you ever had a fixed bridge?
5. Have you ever had removable partial?
6. Have you ever had complete denture?
7. Have you ever had implants?
   If so, are you happy with the replacements? Yes No
8. Have you ever had periodontal treatment?
9. Have you ever had gum surgery?
   If so, when?
   by whom?
10. Have you ever had your teeth ground or bite adjusted?
11. Have you ever had a serious injury to the mouth or head?
    If so, please describe (include cause):
12. Do you feel anxiety about having dental treatment?
    How did you overcome your anxiety?
13. Have you ever had an upsetting dental
    experience? If yes, please describe:

***Smile Characteristics***

**YES NO**

1. Do you like the appearance of your teeth and smile?
2. Do you like the color of your teeth?
3. Would you like your teeth straightened?
4. What would you like to change most in the appearance of your teeth?

***Tooth Structure***

1. Are any of your teeth sensitive to hot or cold liquids/foods?
2. Are any of your teeth sensitive to sweet or sour liquids/foods?
3. Are any of your teeth sensitive to biting or pressure?
4. Have you noticed any loose teeth or change in your bite?
5. Do you get food caught between your teeth?

***Gum and Bone***

1. Have you ever noticed any mouth odors or bad taste?
2. Do you frequently get cold sores, blisters, or any lesions?
3. Do your gums bleed or hurt?
4. Have your parents experienced gum disease or tooth loss?

***Bite and Jaw Joint***

1. Do you clench or grind teeth (awake or asleep)?
2. Do you have tired jaws (especially in the morning)?
3. Do you bite your lips or cheeks regularly?
4. Do you hold foreign objects with your teeth (pencils, pens, nails, fingernails, pipe)?
5. Do you mouth breathe while asleep or awake?
6. Do you snore?
7. Have you ever experienced clicking or popping of the jaw?
8. Have you ever experienced pain (joint, ear or side of face)?
9. Have you ever experienced difficulty opening or closing the mouth?
10. Have you ever experienced frequent headaches, neck aches, or shoulder aches?
11. Have you ever experienced any pain or soreness in the muscles of your face or around the ears?

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

**I consent to the doctor's exam and necessary diagnostics for treatment including x-rays.**

Doctor comments