DENTAL HISTORY

PATIENT NAME: ________________________ MEDICAL ALERT: ____________________

Welcome! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.
What is the reason for your visit today? ____

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Previous dentist: ________________ **Location:** ______________________________
Date of last exam: ____________ **Last cleaning:** _________ **Last x-rays:** ____________

Are any of your teeth sensitive to:
Hot or cold? Yes No
Sweets? Yes No
Biting or chewing? Yes No
Have you noticed any bad breath? Yes No
Bad tastes? Yes No
Do you frequently get cold sores? Yes No
Canker sores? Yes No
Do your gums bleed or hurt? Yes No
Have you noticed any loose teeth? Yes No
or change in your bite? Yes No
Does food tend to get caught between your teeth? Yes No
If yes, where? __________________________

Do You:
Clench or grind your teeth while awake or asleep? Yes No
Bite your lips or cheeks regularly? Yes No
Hold foreign objects with your teeth? Yes No
(pencils, pens, nails, fingernails)
Mouth breath while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No
Smoke or chew tobacco? Yes No
If yes, for how long? ________________
How much? ____________________
Are you interested in quitting? Yes No
Have chronic sinus problems? Yes No

Home Care
How often do your brush your teeth? ______________
Manual or electric brush? ____________________
How often do you floss? ____________________
Any other dental aids? ____________________

☐Fluoride ☐Toothpicks ☐Mouthwash

Any Family History of:
Oral cancer? Yes No
Periodontal (gum) disease? Yes No
Early tooth loss? Yes No
Excessive decay? Yes No

Have you ever had:
Orthodontic treatment (braces)? Yes No
Oral surgery? Yes No
Prolonged healing or bleeding problems? Yes No
Periodontal (gum) treatment? Yes No
A bite splint or mouth guard? Yes No
A full or partial denture? Yes No
If yes, date of placement ____________________
Mouth, head or neck injury? Yes No
If yes, please explain ____________________

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Have you experienced:
Clicking or popping of the jaw? Yes No
Pain (joint, ear, side of face)? Yes No
Difficulty in opening or closing your mouth? Yes No
Difficulty in chewing on either side of mouth? Yes No
Frequent headaches, neck aches or shoulder aches? Yes No

Are you satisfied with the appearance of your teeth? Yes No

Would you like:
Straighter teeth? Yes No
Whiter teeth? Yes No

Do you feel nervous about having dental treatment? Yes No
If yes, what is your biggest concern?

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Have you ever had an upsetting dental experience?

If yes, please describe ____________________

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Doctor Comments:____________________________
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X____ Date: ____________________
Signature of patient (or parent if minor)

Please complete other side of form