DENTAL HEALTH HISTORY

(All information is completely confidential)

What is the reason for your visit today? ______________________________________
Date of last dental visit _____________ Name of Dentist:______________________
Dentist's phone number __________________ City & State ____________________
Date of last dental cleaning _________________________ X-rays: ______________

	YES	NO
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you want complete and comprehensive dental care?	☐	☐
Do you want to keep your teeth for your entire life?	☐	☐

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

Do you gag easily?	☐	☐
Does food catch between your teeth?	☐	☐
Do you wear dentures or partials?	☐	☐
Do you have difficulty chewing your food?	☐	☐
Do you chew only on one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever notice slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive to hot, cold, pressure, sweets, sours, floss?	☐	☐
Do you take fluoride supplements?	☐	☐
Does your jaw make noise that bothers you or others?	☐	☐
Do your jaws ever feel tired?	☐	☐
Do you clench or grind your teeth or jaws?	☐	☐
Does your jaw ever get stuck so that you can't open your mouth freely?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Does it hurt when you chew or open wide?	☐	☐
Do you have earaches or pain in front of your ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine?	☐	☐
Do you find jaw pain or discomfort frustrating or depressing?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat or temples?	☐	☐
Do you take medication for pain or discomfort? (pain relievers, muscle relaxants, antidepressants)	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you noticed any loose teeth or change in your bite?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐
Do you mouth breath while awake or asleep?	☐	☐
Do you notice any mouth odors or bad tastes?	☐	☐
Do you, or any member of your family, get cold sores, blisters, or other oral lesions?	☐	☐

Do you have or have you ever had:	YES	NO
Orthodontic treatment?	☐	☐
Oral Surgery?	☐	☐
Periodontal (Gum) disease?	☐	☐
A mouth or night guard?	☐	☐
A serious injury or blow to your mouth or head?	☐	☐

If yes, please describe: ____
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Is there anything else about your oral health or previous dental treatments that we should know?

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