PATIENT NAME:_____ **DENTAL HISTORY**

All information is completely confidential.

What is the reason for you visit today? _____

_____

Date of last dental visit: _____ Last dental cleaning: _____Last full mouth x-rays: _____
Previous Dentist's Name: _____
Address: _____
Telephone: _____

How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
What other dental aids do you use? (Waterpik, tooth pick, ect.) _____

Do you have dental problems now? YES NO
If yes please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	YES	NO
Sweets?	YES	NO
Biting or chewing?	YES	NO
Do you frequently get cold sores, blisters or any other lesions?	YES	NO
Do your gums bleed or hurt?	YES	NO
Have your parents experienced gum disease or tooth loss?	YES	NO
Have you noticed any loose teeth?	YES	NO
Have you noticed any change in your bite?	YES	NO
Does food tend to become caught between your teeth?	YES	NO

If so, where?_____

Do you:

Clench or grind your teeth while awake or sleeping?	YES	NO
Bite your lips or cheek regularly?	YES	NO
Hold foreign objects with your teeth (pencils, pipe, pins, nails)?	YES	NO
Mouth breathe while awake or asleep?	YES	NO
Have tired jaw?	YES	NO
Smoke or chew tobacco?	YES	NO

If yes, how many packs a day? _____

Have you ever had:

Orthodontic treatments? (braces)	YES	NO
Oral surgery?	YES	NO
Periodontal treatment? (treatment for gums)	YES	NO
A bite plate or mouth guard?	YES	NO
A serious injury to the mouth or head?	YES	NO

If so, please describe, including cause:_____

_____

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?	YES	NO
Are you satisfied with your teeth's appearance?	YES	NO

If not, what would you like to change?_____

_____

Would you like to keep all your teeth all your life?	YES	NO
Do you feel nervous about having dental treatments?	YES	NO

If so, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience?	YES	NO

If so, please describe: _____

_____

Is there anything else about having dental treatment that you would like for us to know? YES NO
If so, please describe: _____

_____