DENTAL HISTORY

What is the reason for your visit today? _____

_____

Date of Last Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

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? (Interplak, Proxabrush, etc.) _____

Do you have any 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
Have you noticed any mouth odors or bad tastes?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have you noticed any loose teeth or changes in your bite?	Yes	No
Does food get caught in between your teeth?	Yes	No
If yes, where?	_____	
Do you have any teeth which are tender to biting pressure?	Yes	No
Have your teeth separated creating spaces between them?	Yes	No

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Smoke/Chew tobacco?	Yes	No
If yes, how much?	_____	
How long?	_____	
Do you drink some form of alcohol daily?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
If so, when?		

_____

_____

Have you had your teeth grounded or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, describe, including cause:		

_____

_____

Have you experienced?

Clicking or popping of the jaw?	Yes	No
Do you awaken with pain near your ears or jaw muscles?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
A bite that feels uncomfortable or unusual?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Do you feel nervous about having dental treatment?	Yes	No