

Patient Name
Today's Date

# DENTAL HISTORY

Medical Alert
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What is the reason for your visit today? \_\_\_\_\_

Rate your current dental health as:     Good     Fair     Poor

Date of last dental visit \_\_\_\_\_ Last dental cleaning \_\_\_\_\_ Last full mouth X-rays \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's name \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Manual or electric toothbrush? \_\_\_\_\_ What brand? \_\_\_\_\_

What other dental aids do you use? (Interplak, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now?     Yes     No

If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**    YES    NO

Hot or cold?       

Sweets?       

Biting or Chewing?       

Have you noticed any mouth odors or bad tastes?       

Do you frequently get cold sores, blisters or other oral lesions?       

Any other oral lesions?       

**Do your gums bleed or hurt?**       

Have your parents experienced gum disease or tooth loss?       

Have you noticed any loose teeth or change in your bite?       

Does food tend to become caught in between your teeth?       

If yes, where? \_\_\_\_\_

**Do you:**

Clench or grind your teeth while awake or asleep?       

Bite your lips or cheeks regularly?       

Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)       

Mouth breathe while awake or asleep?       

Smoke/Chew tobacco       

Do you have any concerns regarding your dental visit?       

\_\_\_\_ fear    \_\_\_\_ pain    \_\_\_\_ time    \_\_\_\_ money    \_\_\_\_ embarrassment

(Rate from 1 to 5. 1=most concerned 5=not concerned)

other (explain) \_\_\_\_\_

Do you feel nervous about having dental treatment?       

If so, what is your biggest concern? \_\_\_\_\_

Have you ever had an upsetting dental experience?       

If yes, please describe: \_\_\_\_\_

**Have you ever had:**    YES    NO

Nitrous oxide (laughing gas)       

or taken anti-anxiety medications for dental treatment?       

If yes, please specify: \_\_\_\_\_

Orthodontic treatment?       

Oral surgery?       

Periodontal treatment?       

Your teeth ground, or the bite adjusted?       

A bite plate or mouth guard?       

A serious injury to the mouth or head?       

If so, please describe, including cause: \_\_\_\_\_

**Have you experienced:**

Clicking or popping of the jaw?       

Pain? (joint, ear, side of face)       

Difficulty in opening or closing the mouth?       

Headaches, neckaches or shoulder aches?       

Sore muscles? (neck, shoulders)?       

Pain on clenching your teeth?       

**Are you satisfied with your teeth's appearance?**       

If no, what would you like to change? \_\_\_\_\_

Would you like to keep all your teeth all your life?       

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

If yes, please describe: \_\_\_\_\_