

Patient Name
Today's Date

DENTAL HISTORY

Medical Alert

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? YES NO

Sweets? YES NO

Biting or Chewing? YES NO

Have you noticed any mouth odors or bad tastes? YES NO

Do you frequently get cold sores, blisters or other oral lesions? YES NO

Any other oral 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 or change in your bite? YES NO

Does food tend to become caught in 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?

(pencils, pipe, pins, nails, fingernails) YES NO

Mouth breathe while awake or asleep? YES NO

Smoke/Chew tobacco YES NO

Do you have any concerns regarding your dental visit? YES NO

___fear ___pain ___time ___money ___embarrassment

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

q other (explain) _____

Do you feel nervous about having dental treatment? YES NO

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) YES NO

or taken anti-anxiety medications for dental treatment? YES NO

If yes, please specify: _____

Orthodontic treatment? YES NO

Oral surgery? YES NO

Periodontal treatment? YES NO

Your teeth ground, 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, 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 the mouth? YES NO

Headaches, neckaches or shoulder aches? YES NO

Sore muscles? (neck, shoulders)? YES NO

Pain on clenching your teeth? YES NO

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

If no, what would you like to change? _____

Would you like to keep all your teeth all your life? YES NO

Is there anything else about having dental treatment that you would like us to know? YES NO

If yes, please describe: _____