DENTAL HISTORY FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Patient Name: _____

Date (approximate) of your last Dental Visit: _____

Date (approximate) of your last Dental Cleaning: _____

Date (approximate) of your last Full Mouth X-Ray: _____

Previous Dentist's Name: _____

Address: _____ State _____ Zip _____

Telephone: _____

How frequently do you have your teeth examined? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Are there any other dental aids that you use? _____

What are some typical foods you eat between meals?_____

_____

How often do you chew or suck on hard candy, cough drops or mints?_____

Do you drink coffee? _____

Do you use fluoride toothpaste? _____

Please check **Yes** or **No** to the following questions:

Have you had one or more fillings in the last three years? □ Yes □ No
Do you have family history of extensive decay? □ Yes □ No
Do you have a family history of periodontal disease? □ Yes □ No
Have you had oral surgery? □ Yes □ No
Do you have dry mouth or excessive thirst? □ Yes □ No
Do you have sensitive teeth? □ Yes □ No
If yes, are you sensitive to: □ Hot □ Cold □ Pressure □ Sweets
Are you aware of any swelling or lumps in your mouth? □ Yes □ No
Do you have difficulty chewing? □ Yes □ No
Do you hear popping/clicking/snapping in your jaw? □ Yes □ No
Do you have jaw pain? □ Yes □ No
Do you have difficulty in opening or closing the mouth? □ Yes □ No
Headaches, neck aches, or shoulder aches? □ Yes □ No
Do your gums bleed or hurt? □ Yes □ No
Have you experienced gum disease or tooth loss? □ Yes □ No
Have you noticed any loose teeth or change in your bite? □ Yes □ No
Are you on any current medications? □ Yes □ No
If yes, please list the following:

Medication Name	Dosage	Frequency

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? (pens, nails, etc) □ Yes □ No
Mouth breathe while awake or asleep? □ Yes □ No
Have tired jaws, especially in the morning? □ Yes □ No
Snore or have any other sleeping disorders? □ Yes □ No
Smoke/chew tobacco or use other tobacco products? □ Yes □ No
If yes, please describe the type, amount, and number of years using tobacco:

_____

_____

Have you ever had:
Orthodontic treatment? □ Yes □ No
Oral surgery? □ Yes □ No
Periodontal treatment? □ Yes □ No

Any teeth pulled? □ 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

Does food get stuck between certain teeth in your mouth? □ Yes □ No
Are you dissatisfied with the way your teeth look? □ Yes □ No
Can you see your fillings when you smile? □ Yes □ No

Do you ever avoid any areas of your teeth while brushing? □ Yes □ No
Have you had an unpleasant odor or taste in your mouth? □ Yes □ No

If yes to any of the above, please describe: _____

_____

_____

Is there anything else you would like us to know?

_____

_____

_____