Dental History

Welcome! Please complete this dental/medical history form so that we may provide you with the best possible dental care. All information is completely confidential.

What is the reason for your visit today? _____

Date of last dental visit: _____ Last dental cleaning: _____ Last x-rays: _____

Previous Dentist's name: _____ phone # _____

Address _____ State _____ Zip _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever of are you currently using topical fluoride? _____

What other dental aids do you use? (toothpick, water pic, ect…) _____

Do you have any dental problems now? (if yes please describe)_____

_____

Are your teeth sensitive to:

Hot or cold	yes	no
Sweets	yes	no
Biting	yes	no
Have you noticed any mouth odors or bad taste	yes	no
Do frequently get cold sores, blisters, or any other oral lesions	yes	no
Do your gums hurt or bleed	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 or your spouse have the following?

Sleep apnea	yes no
Do you snore	yes no
Have you had sleep studies	yes no
CPAP	yes no

DO YOU:

Clench your teeth while awake or asleep	yes no
Bite your lips or cheeks regularly	yes no
Hold foreign objects with your teeth (pencils, pins, nails…)	yes no
Mouth breathe while awake or asleep	yes no
Have tired jaws, especially in the morning	yes no
Snore or have any other sleep disorder	yes no
Smoke/chew tobacco or use any other tobacco products	yes no

HAVE YOU EVER HAD:

Orthodontic treatment	yes no
Oral surgery	yes no
Periodontal treatment	yes no
Your teeth ground or your bite adjusted	yes no
A serious injury to the mouth or head	yes no

If yes please describe the cause _____

HAVE YOU EXPERIENCED:

Clicking or popping of the jaw	yes no
Pain in the joint, ear, or side of face	yes no
Difficulty opening or closing the mouth	yes no
Difficulty in chewing on either side of the mouth	yes no
Headaches, neck aches, shoulder aches	yes no
Are you satisfied with your teeth's appearance?	yes no
Would you like to keep all of your teeth all of your life?	yes no
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?	yes no

If yes please describe _____