DENTAL HISTORY

_____
Patient Name

1. What is the reason for your visit today? _____
   _____
2. Date of last dental visit _____Last dental cleaning_____Last xrays _____
3. What was done at your last dental visit? _____
   _____
4. Previous dentist's name_____
   Address _____ City_____ State _____
   Telephone _____
5. How often do you have dental examinations? _____
6. How often do you brush your teeth? _____ How often do you floss? _____
7. What other dental aids do you use? (sonicare, toothpick, rubber tip, etc) _____
8. 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 any other oral lesions?	**Have you ever had:** Yes No Orthodontic treatment Yes No Oral Surgery Yes No Periodontal treatment Yes No Your teeth ground or bite adjusted Yes No A nightguard or bitesplint Yes No A serious injury to the mouth or head If so, please describe, including cause: _____
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? If yes, where? _____	**Have you experienced:** Yes No Clicking or popping of the jaw Yes No Pain in jaw joint, ear or side of face Yes No Difficulty in opening or closing mouth Yes No Difficulty in chewing on either side of mouth Yes No Headaches, neckaches or shoulder aches Yes No Sore muscles in neck or shoulders
Do you: Yes No 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 such as pencils, pins, nails, pipe, fingernails Yes No Mouth breathe while awake or asleep Yes No Have sore jaw muscles in the morning Yes No Smoke or chew tobacco	Yes No **Are you satisfied with your teeth's appearance?** Yes No Do you feel nervous about having dental treatment? If so, what is your biggest concern? _____ _____ Yes No Do you use nitrous oxide (laughing gas) for dental treatment? Yes No Have you ever had an upsetting dental experience? If yes, please describe _____ _____

If there is anything else about having dental treatment that you would like us to know, please describe:
_____

Patient / Guardian Signature _____ Date _____