**DENTAL HISTORY**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date of last dental visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental cleaning\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental x-rays\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Type of x-rays taken\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any dental problems now? Yes No If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does dental treatment make you nervous? \_\_\_\_No \_\_\_\_Slightly \_\_\_\_Moderately \_\_\_\_Very

Is there anything else you would like us to know about your mouth, your teeth or your smile?

­­­ Is there anything else about receiving dental treatment that you would like us to know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Are your teeth sensitive to:** | **Yes** | **No** | **Have you ever had:** | **Yes** | **No** |
| Hot or cold? |  |  | Orthodontic treatment? |  |  |
| Sweets? |  |  | Oral Surgery? |  |  |
| Biting or chewing? |  |  | Periodontal treatment? |  |  |
| Do your gums bleed or hurt? |  |  | Your teeth ground or the bite adjusted? |  |  |
| Do you frequently get cold sores, blisters or other oral lesions? |  |  | A night guard or brux guard? |  |  |
| A serious injury to the mouth or head? |  |  |
| Have you noticed any loose teeth or change in your bite? |  |  | **Have you ever experienced:** | **Yes** | **No** |
| Clicking or popping of the jaw? |  |  |
| Does food tend to become caught in between your teeth? |  |  | TMJ pain? |  |  |
| Difficulty opening or closing the mouth? |  |  |
| **Do you**: | **Yes** | **No** | Headaches, neck, or shoulder aches? |  |  |
| Clench or grind your teeth? |  |  | **Do you smoke or use tobacco?** |  |  |
| Bite your lips or cheeks often? |  |  | Have you ever had an upsetting dental experience? |  |  |
| Hold foreign objects with your teeth? (pencils, nails, etc.) |  |  |
| **Are you satisfied with your teeth’s**  **appearance?** |  |  |
| Use a CPAP machine? |  |  |