

**DENTAL HISTORY**

PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTH DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last: Dental Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dental Cleaning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mouth X-Rays \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Dental Aids do you use (e.g. Interplak, toothpick, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any current dental problems? Yes No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are your teeth sensitive to? **Have you ever had?**

hot or cold? Yes No Orthodontic treatment? Yes No

sweets? Yes No Oral Surgery? Yes No biting or chewing? Yes No Periodontal Treatment? Yes No

Do you have mouth odors? Yes No Your teeth ground or bite adjusted? Yes No

Do you have a bad taste? Yes No A bite plate or mouth guard? Yes No

Do you frequently have cold sores, A serious injury to the mouth or head? Yes No

blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Has anyone in your family had gum

disease or tooth loss? Yes No **Have you experienced:**

Do you have any loose teeth? Yes No Clicking or popping of the jaw? Yes No

Has your bite changed? Yes No Pain (joint, ear, side of face)? Yes No

Does food often get caught between Difficulty in opening/closing mouth? Yes No

your teeth? Yes No Difficulty chewing or either side of

 mouth? Yes No

 Headaches, neck aches or shoulder

**Do You:** aches? Yes No

Clench or grind your teeth when

awake or asleep? Yes No

Bite your lips or cheeks? Yes No Are you pleased with the appearance

Bite on foreign objects (e.g. pencils, of your teeth? Yes No

pipe, pen, fingernails, etc.) Yes No If no, what would you like to change?

Mouth breathe when awake or asleep? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have tired jaws when you wake up \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

morning? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snore or have any sleep disorder? Yes No Have you ever taken pre-medication

Smoke or chew tobacco? Yes No prior to dental treatment? Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be

dangerous to my (or patient’s) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_