## 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	n drops or mints?	
Do you drink coffee?		
Do you use fluoride toothpaste?		

i lease effects i es of 140 to the following questions	Please check	Yes or	No to	the f	following	questions
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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 □ Press	sure □ 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 Fr	requency
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?	
If yes, please describe the type, amount, and number	ber of years using tobacco:
Have you ever had:	
Orthodontic treatment?	□ Yes □ No
Oral surgery?	□ Yes □ No
Periodontal treatment?	□ Yes □ No

Any teeth pulled? Your teeth ground or the bite adjusted?	□ Yes □ No □ 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?	
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?	