

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 drops or mints? _____

Do you drink coffee? _____

Do you use fluoride toothpaste? _____

Please check **Yes** or **No** to the following questions:

- 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 ☐ Pressure ☐ 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:

<u>Medication Name</u>	<u>Dosage</u>	<u>Frequency</u>
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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? ☐ Yes ☐ No

If yes, please describe the type, amount, and number of years using tobacco:

Have you ever had:

- Orthodontic treatment? ☐ Yes ☐ No
Oral surgery? ☐ Yes ☐ No
Periodontal treatment? ☐ Yes ☐ No

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