

PATIENT'S DENTAL HISTORY

Name: _____ Date of Birth: __/__/__

Reason for this visit:

When was your last dental visit

How often did you visit the dentist before then:

Previous Dentist (Name and Location):

Have you had a complete series of dental films (x-rays) taken when/where:

How often do you brush your teeth? How often do you floss your teeth?

Do your gums bleed while brushing or flossing?	Yes	No
Are your teeth sensitive to hot or cold liquids/foods?	Yes	No
Are your teeth sensitive to sweet or sour liquids/foods?	Yes	No
Do you feel pain to any of your teeth?	Yes	No
Do you have any sores or lumps in or near your mouth?	Yes	No
Have you had any head, neck or jaw injuries?	Yes	No
Have you ever experienced any of the following problems in your jaw?	Yes	No
Clicking	Yes	No
Pain (joint, ear, side of face)	Yes	No
Difficulty in opening or closing	Yes	No
Difficulty in chewing	Yes	No
Do you have frequent headaches?	Yes	No
Do you clench or grind your teeth?	Yes	No
Do you bite your lips or cheeks frequently?	Yes	No
Have you noticed any loosening of your teeth?	Yes	No
Does Food tend to become caught between your teeth?	Yes	No
Have you ever had periodontal treatment (Gums)?	Yes	No
Ever worn a bite plate or other appliance?	Yes	No
Have you ever had any difficult extractions in the past?	Yes	No
Have you ever had any prolonged bleeding following extractions?	Yes	No
Do you wear dentures or partials?	Yes	No
If yes, date of placement:	Yes	No
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	Yes	No

If you could change anything about your smile, what would you change? _____
