

Dental History

Patient Name: _____

Date: _____

Date of your last dental visit: _____

Date of your last dental cleaning: _____

Date of last full mouth series of x-rays: _____

Do you have any dental problems now? Yes No

Do you have any teeth that are sensitive to hot , cold or sweets? Yes No

Have you ever had:

Orthodontic treatment ? Yes No

Oral surgery ? Yes No

Periodontal treatment ? Yes No

Your teeth ground or bite adjusted ? Yes No

Worn a bite plate or other appliance ? Yes No

Have you noticed any loosening of your teeth ? Yes No

Does food tend to become caught between your teeth? Yes No

Do you suffer from pain and/ or swelling of your gums ? Yes No

Do your gums often bleed when you brush your teeth ? Yes No

Do you feel you have bad breath ? Yes No

Have you experienced any problems of the jaw, such as;

Clicking, pain, headaches, difficulty opening/closing, or difficulty chewing? Yes No

Have you ever had jaw surgery or a broken jaw ? Yes No

Do you clench or grind your teeth while awake or asleep? Yes No

Do you breath through your mouth while awake or asleep ? Yes No

Do you snore ? Yes No

Do you feel very nervous about having dental treatment? Yes No

Have you ever had an upsetting experience in a dental office ? Yes No

Is there anything else about having dental treatment that bothers you ? Yes No

Do you expect to eventually lose your teeth? Yes No

Are you dissatisfied with the appearance of your teeth ? Yes No

Do you feel your teeth are crowded or crooked ? Yes No

Do you feel your teeth are yellow, dark or stained ? Yes No

Do you feel your smile could be improved ? Yes No

Any comments: _____

