Dental History

Referred by_____
Previous Dentist_____ Last visit_____
Most recent dental exam_____ Most recent X-rays_____
Most recent dental treatment_____
How often do you have your teeth cleaned? 3mo._____ 4mo._____ 6mo._____ 1yr or longer_____
What is your immediate dental concern? _____

Please answer YES or NO to the following questions:

	Yes	No
Are you unhappy with the appearance of your teeth?	☐	☐
Have you had unfavorable dental experiences?	☐	☐
Do you have dental fears?	☐	☐
Have you had problems with effectiveness or bad reactions to dental anesthetic?	☐	☐
Have you had Orthodontic treatment (Braces), if so, when? _____	☐	☐
Have you had periodontal (gum) treatment, if so, when? _____	☐	☐
Do you have bleeding gums?	☐	☐
Do you avoid brushing any part of your mouth?	☐	☐
Is any part of your mouth sensitive to temperature?	☐	☐
Do you have difficulty swallowing?	☐	☐
Do you have an unpleasant taste or odor in your mouth?	☐	☐
Do you have dry mouth, throat, and or eyes?	☐	☐
Do you/would you have any problems chewing bagels or other hard foods?	☐	☐
Do you have any sore teeth?	☐	☐
Do you/would you have any problems chewing gum?	☐	☐
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
Do you have stiff neck muscles?	☐	☐
Do you have more than one bite or do you clench (squeeze) to make your teeth fit better?	☐	☐
Do you experience tension headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you have problems with sleep or wake up with an awareness of your teeth?	☐	☐
Have you lost any teeth?	☐	☐
Do you have problems with your jaw joint (pain sounds, limited opening, locking, popping)?	☐	☐
Do you wear or have you worn a bite appliance?	☐	☐

Supplemental Denture History:
If you are wearing a partial or complete artificial denture, please complete the following:

Has your present Denture been relined? When?_____	☐	☐
Is your present Denture a problem? Describe _____	☐	☐
Are you satisfied with the appearance?	☐	☐
Are you satisfied with the comfort?	☐	☐
Satisfied with the chewing ability?	☐	☐
When did you receive your first partial or complete denture? _____		
How long have you worn your present denture? _____	☐	☐

Patient Signature_____ Date _____

Doctor Remarks _____

Doctor Signature _____ Date _____