gradelessdental

DENTAL HISTORY

Patient Name:

What is the reason for your visit today?

_____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

How often do you have dental examinations? _____

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

Have you ever used or are currently using topical fluoride? Yes ◯ No ⊙

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes ◯ No ◯

If yes, please describe: _____

Are you satisfied with your teeth's appearance? ☐ Yes ☐ No

Would you like to keep all of your teeth all of your life? ☐ Yes ☐ No

Have you noticed any mouth odors or bad tastes? ☐ Yes ☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No

Have your parents experienced gum disease or tooth loss? ☐ Yes ☐ No

Have you noticed any loose teeth or change in your bite? ☐ Yes ☐ No

Does food tend to get caught between your teeth? ☐ Yes ☐ No

If so, where? _____

Do You:

Clench or grind your teeth while awake or asleep? ☐ Yes ☐ No

Bite your lips or cheeks regularly? ☐ Yes ☐ No

Frequently get cold sores, blisters, or any other oral lesions? ☐ Yes ☐ No

Hold foreign objects with your teeth? (pencils, pipe, etc.) ☐ Yes ☐ No

Mouth breathe while awake or asleep? ☐ Yes ☐ No

Have tired jaws, especially in the morning? ☐ Yes ☐ No

Have sleep apnea or use a CPAP? ☐ Yes ☐ No

Snore or have any other sleeping disorders? ☐ Yes ☐ No

Smoke/chew tobacco or use other tobacco products? ☐ Yes ☐ No

Are any of your teeth sensitive to:

Hot or cold? ☐ Yes ☐ No

Sweets? ☐ Yes ☐ No

Biting or Chewing? ☐ Yes ☐ No

Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No

Oral Surgery? ☐ Yes ☐ No

Periodontal treatment? ☐ 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

Please describe: _____

Have you experienced:

Clicking or popping of the jaw? ☐ Yes ☐ No

Pain? (joint, ear, side of face) ☐ Yes ☐ No

Difficulty opening or closing the mouth? ☐ Yes ☐ No

Difficulty chewing on either side of the mouth?. ☐ Yes ☐ No

Sore muscles? (neck, shoulders) ☐ Yes ☐ No

Headaches, neckaches, or shoulder aches? ☐ Yes ☐ No

What aspect of dental treatment creates the most anxiety for you? _____

_____

Please describe any upsetting dental experiences: _____

_____

Have you ever been told to take a pre-medication prior to dental work? ☐ Yes ☐ No

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No

If yes, please describe: _____

_____

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