DENTAL HISTORY

Patient Name: _____ Date: _____

What is the reason for your visit today? _____
Date of last dental visit: _____ Date of last dental cleaning: _____
Date of last full mouth x-ray series: _____ (18 different pictures)
What was done at your last dental visit?

_____
Previous dentist's name:_____Address:_____
Previous dentist's phone: _____
How often do you have dental examinations?_____
How often do you brush your teeth? _____How often do you floss?_____
What other dental aids do you use? (Sonicare, fluoride rinse, floss threader, etc.,)

_____
Do you have any dental problems now? Yes No
If yes, please describe: _____

_____

Are any of your teeth sensitive to:

Hot or cold? Yes No
Sweets? Yes No
Biting or chewing? 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 become caught in between your teeth? Yes No
If yes, where? _____

Have you ever had:

Orthodontic treatment Yes No
Oral surgery Yes No
Scaling & root planing Yes No
Gum surgery Yes No
Your bite adjusted Yes No
A bite plate or mouthguard Yes No
Serious injury to your mouth or head Yes No
If yes, please describe, including cause & date of accident _____

Do you:

Clench or grind your teeth while awake or asleep? Yes No
Bite your lips or cheeks regularly? Yes No
Chew on pencils, pipe, pens nails, fingernails? Yes No

Have you experienced:

Clicking or popping of your jaw Yes No
Pain (joint, ear, side of face) Yes No
Difficulty in opening or closing your mouth Yes No
Headaches, neck or shoulder pain Yes No
Sore muscles (neck, shoulders) Yes No

How often do you:

Have tired jaws, especially in the morning? Never Sometimes Frequently Always
After a full night's sleep (at least 6 hours), how rested do you feel?
(not rested at all) 1 2 3 4 5 6 7 8 9 10 (fully rested)
Snore while sleeping? Never Sometimes Frequently Always
Feel sleepy during the day? Never Sometimes Frequently Always
Have heartburn or gastric reflux? Never Sometimes Frequently Always
Wake up at night and have trouble falling back to sleep? Never Sometimes Frequently Always
Wake up early and can't go back to sleep? Never Sometimes Frequently Always
Experience uncomfortable and/or restless sensations in your legs at night? Never Sometimes Frequently Always
Notice your legs moving or jerking at night? Never Sometimes Frequently Always
Wake up gasping for breath? Never Sometimes Frequently Always
Fall asleep while driving? Never Sometimes Frequently Always