

Dental History

Date _____

Please answer the following questions to the best of your ability:

Date of most recent dental exam / cleanings _____ Any x-rays taken at this time? _____

Date of most recent dental treatment _____ Treatment performed _____

IMMEDIATE DENTAL CONCERNS? _____

Please mark YES or NO to the following questions:

YES NO

- Do your gums bleed when brushing, flossing or eating?
- Do you have difficulty brushing or flossing an area? Does food collect between your teeth?
- Do you have a bad taste or odor in your mouth?
- Do you have any loose teeth, or have any teeth moved or shifted within the past two years?
- Do you or have you ever smoked? (packs/day _____) When did you quit? _____
- Have you ever been diagnosed or treated for periodontal disease? Any family history?
- Do you floss, use a water jet device, interdental stimulator, or proxy brush?

- Do you have toothaches, sore teeth or dental pain?
- Are your teeth sensitive to hot, cold, sweets, biting, or touch?
- Do you have any broken teeth, missing fillings, or root canals?
- Do you have a dry mouth?
- Do you drink fluoridated water or take fluoride supplements?
- Have you had cavities diagnosed or treated within the past two years?
- Have you ever had a dental implant?

- Do you clench or grind your teeth? Are you awake or asleep when it occurs?
- Do you have soreness or pain in your jaw, ear, or side of your face?
- Do you get frequent headaches?
- Does your jaw ever pop, click, lock, or become fatigued or tired?
- Do you have difficulty opening, closing, or chewing certain types of foods?
- Do your teeth come together unevenly or do you hit one tooth before the others when you bite?
- Do you wear a splint, nightguard or had an injury to the head/neck including an auto accident?

- Are you dissatisfied with the appearance of your teeth?
- Do you dislike the color of your teeth or have noticeable spots or stains?
- Do you have existing crowns or dental work which you consider "ugly"?
- Do you have chips, spaces, crowded or crooked teeth that bother you?
- Are you self-conscious of your teeth or smile or has anyone suggested you change your smile?
- Would you like to improve your smile?

- Have you ever had complications from past dental treatment?
- Have you experienced any complications or reactions from local anesthetic?
- Have you ever had teeth extracted?
- Did you ever have braces or orthodontic treatment?
- Do you have any lumps, sores, or growths in your mouth?
- Does dental treatment cause you much worry or concern?
- Have you had an unpleasant dental experience in the past?
- Do you think your teeth are affecting your general health?

Supplemental Partial/Denture History On next page

Patient Signature: _____ **Date:** _____

Supplemental Dental History

Supplemental Denture/ Partial History

If you are wearing a partial or complete artificial denture, please complete the following questions by marking yes or no.

YES NO

- Has your present denture been relined?
- Is your present denture a problem? Please describe _____

- Are you satisfied with the appearance?
- Are you satisfied with the comfort?
- Are you satisfied with the chewing ability?
- When did you receive your first partial or complete denture? _____
- How long have you worn your present partial or denture? _____