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DENTAL HISTORY

DATE: ___/ ___/ ____

DATE OF LAST DENTAL VISIT _____ PURPOSE ______ HOW OFTEN DO YOU SEE DENTIST? ____________

ARE YOU HAVING ANY DENTAL PROBLEM THAT REQUIRES IMMEDIATE ATTENTION? ________________

DO YOU HAVE A FEAR OF DENTAL PROCEDURES? ________ IF YES INDICATE LEVEL (from 1 to 10, 10 the highest)

WOULD YOU LIKE TO BE SEDATED FOR DENTAL PROCEDURES? ___________________________________

DOES ANY ONE OF THE FOLLOWING CAUSES TOOTH DISCOMFORT?
HOT ___ COLD ___ SWEETS ___ CHEWING ___

HOW OFTEN DO YOU BRUSH YOUR TEETH? _________________ FLOSS? ______ WATER JET? _________

DOES YOUR GUMS BLEED WHILE CLEANING? ____________ DO YOU GUMS EVER FEEL TENDER OR SWOLLEN? ____

DO YOUR JAWS EVER FEEL TIRED OR ACHE? _________________ CLICK OR POP? ___________________

CAN YOU CHEW ON BOTH SIDES OF YOUR MOUTH? ____________________ COMFORTABLY? ________

DO YOU HAVE FREQUENT HEADACHES? __________________________ EARACHES? ________________

HAVE YOU EVER HAD ORTHODONTIC TREATMENTS (BRACES)? _________ WHEN? __________________

DO YOU HAVE LOOSE FILLINGS OR BREAK FILLINGS ____ DO YOU USUALLY HAVE MANY CAVITIES? _____

DO YOU HAVE ANY LOOSE TEETH? ____________ CRACKED OR BROKEN? _________________________

DO YOU HAVE ANY NOTICEABLE WEAR ON YOUR TEETH? ____________ FOOD TRAPS _______________

DO YOU HAVE ANY MISSING TEETH? ___________________ HAVE THEY BEEN REPLACED? ___________

IF SO, HOW? FIXED BRIDGE ____ REMOVABLE PARTIAL ____ FULL DENTURE ____ DENTAL IMPLANT ___

ARE YOU COMFORTABLE WITH THE REPLACEMENT? __________ PLEASE DESCRIBE _________________

HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR SMILE? _________________________________

HAVE YOU EVER HAD ANY COSMETIC DENTISTRY DONE TO IMPROVE YOUR APPEARANCE? ___________

IF YES, ARE YOU PLEASED WITH THE RESULT? __________ PLEASE COMMENT _____________________

HAVE YOU EVER HAD AN UNPLEASANT DENTAL EXPERIENCE? ___________________________________

HAVE YOU EVER HAD FLUORIDE TREATMENT _____ TROUBLE FROM DENTAL EXTRACTION ___________

PERIODONTAL THERAPY ____ PROF. HOMECARE INSTRUCTION ____ DATE OF LAST X-RAY EXAM ______

DO YOU CLENCH OR GRIND YOUR TEETH ____

PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT ____