PATIENT DENTAL HISTORY

PATIENT'S NAME_____DATE OF BIRTH_____

REASON FOR VISIT_____

WHEN WAS YOUR LAST DENTAL VISIT_____ WHAT WAS DONE_____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN_____

PREVIOUS DENTIST (NAME AND LOCATION)_____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (XRAYS) TAKEN- WHERE AND WHEN

_____

HOW OFTEN DO YOU BRUSH YOUR TEETH_____HOW OFTEN DO YOU FLOSS_____

IS YOUR DRINKING WATER FLUORIDATED_____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING, FLOSSING?	___	___
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	___	___
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOOD?	___	___
DO ANY OF YOUR TEETH FEEL PAINFUL?	___	___
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	___	___
HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS:		
• CLICKING IN YOUR JAW	___	___
• PAIN (JOINT, EAR, SIDE OF FACE)	___	___
• DIFFICULTY IN OPENING OR CLOSING YOUR JAW	___	___
• EVER HAD LOCKED OPEN JAW	___	___
• DIFFICULTY IN CHEWING	___	___
DO YOU CLENCH OR GRIND YOUR TEETH?	___	___
HAVE YOU EVER WORN A NIGHT GUARD, SNORE GUARD, ORTHO APPLIANCE?	___	___

	YES	NO
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	___	___
DO YOU HAVE FREQUENT HEADACHES?	___	___
HAVE YOU EVER HAD PERIODONTAL TREATMENT (DEEP CLEANING) OR WERE YOU DIAGNOSED WITH GUM DISEASE?	___	___
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTUCTIONS ?	___	___
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	___	___

HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH? ____ ____

DOES FOOD TEND TO BE CAUGHT BETWEEN YOUR TEETH? ____ ____

HAVE YOU HAD DIFFICULT EXTRACTIONS IN THE PAST? ____ ____

HAVE YOU EVER HAD ANY PROLONGED BLEEDING

FOLLOWING EXTRACTIONS? ____ ____

DO YOU WEAR DENTURES OR PARTIALS? ____ ____

IF YES, WHAT DATE WERE THEY PLACED? ____ ____

SMILE EVALUATION

YES NO

DO YOU LIKE THE WAY YOUR TEETH LOOK? ____ ____

WOULD YOU LIKE YOUR TEETH TO BE WHITER? ____ ____

WOULD YOU LIKE YOUR TEETH TO BE STRAIGHTER? ____ ____

DO YOU HAVE SPACES BETWEEN YOUR TEETH THAT YOU WOULD LIKED CLOSED? ____ ____

WOULD YOU LIKE YOUR TEETH TO BE LONGER? ____ ____

DO YOU LIKE THE SHAPE OF YOUR TEETH? ____ ____

DO YOU HAVE MISSING TEETH THAT YOU WOULD LIKE REPLACED? ____ ____

WOULD YOU LIKE TO REPLACE OLD SILVER FILLINGS WITH TOOTH-COLORED FILLINGS? ____ ____

_____ _____

SIGNATURE OF PATIENT OR PARENT/GAURDIAN DATE

_____ _____

DOCTOR'S SIGNATURE DATE