

Dental History

Name _____
Previous Dentist _____ Period of treatment _____
Address _____ Specialty _____

Last dental visit _____ Last full-mouth xray _____
Last complete dental exam _____
What is your immediate dental concern? _____

Please check **YES** or **NO**

- | Yes | No | |
|-----|-----|-------------------------------------------------------------------------------------------------------------|
| ___ | ___ | Are you presently in any dental pain? _____ |
| ___ | ___ | Is any part of your mouth sensitive to temperature, pressure, food or drink? _____ |
| ___ | ___ | Have you ever experienced any unfavorable reaction to dentistry? _____ |
| ___ | ___ | Have you ever had a bad reaction to a dental anesthetic? When? _____ |
| ___ | ___ | Do you have any growths or swelling in your mouth? How long? _____ |
| ___ | ___ | Do you have any difficulty in swallowing? _____ |
| ___ | ___ | Do you have a burning sensation in your mouth? _____ |
| ___ | ___ | Do your gums bleed when brushing your teeth? _____ |
| ___ | ___ | Do you avoid brushing any part of your mouth? _____ |
| ___ | ___ | Have you ever been told you had pyorrhea? When? _____ |
| ___ | ___ | Does food catch between your teeth? _____ |
| ___ | ___ | Do you have an unpleasant taste or odor in your mouth? _____ |
| ___ | ___ | Do you have any pain or soreness around your eyes, ears or other parts of your face? _____ |
| ___ | ___ | Are you aware of stiff neck muscles? How often? _____ |
| ___ | ___ | Do you ever awaken with an awareness of your teeth or jaws? How often? _____ |
| ___ | ___ | Are you aware of clenching your teeth during the day? _____ |
| ___ | ___ | Have you been told you grind your teeth at night? _____ |
| ___ | ___ | Are you aware of clicking or popping in your jaw while eating or yawning? _____ |
| ___ | ___ | Do you have difficulty in opening your mouth widely? _____ |
| ___ | ___ | Do you have 'tension' headaches? How often? _____ |
| ___ | ___ | Have you lost any teeth? From what cause? _____ |
| ___ | ___ | Do any members of your family had dentures? _____ |
| ___ | ___ | Do you feel you will eventually wear full dentures? _____ |
| ___ | ___ | Are you dissatisfied with you're the appearance of your teeth? _____ |
| ___ | ___ | Have you ever had orthodontic treatment? _____ |
| ___ | ___ | Do you think your dental disease is active? _____ |
| ___ | ___ | Do you want to learn to control your dental disease and retain your teeth? _____ |
| ___ | ___ | Are you deeply concerned about the finances required to return your mouth to excellent dental health? _____ |