# Dental History

Name:_____ Birthdate:_____

What is the reason for your visit today?_____
_____ Are you in pain: Yes / NO

Date of your last dental visit:_____What was done then:_____

Previous dentist (name & location):_____

Date of your last full mouth x-rays:_____ Last dental cleaning:_____

How often do you brush your teeth:_____ How often do you floss your teeth:_____

Do you use fluoridated toothpaste: (*circle one*) Yes / No Name:_____

Primary source of drinking water: (*circle one*) City Water/ Bottled Water/ Well Water/Reverse Osmosis

What types of beverages do you typically drink between meals:_____

Do you use tobacco:_____ Type:_____
Amount:_____ Number of years:_____ How soon after waking do you use tobacco:_____ Previous attempts to quit: Yes / No Number of attempts:_____

| | Yes | No |
|---|---|---|
| Do your gums bleed while brushing or flossing | | |
| Are your teeth sensitive to hot or cold liquids/foods | | |
| Are your teeth sensitive to sweet or sour liquids/foods | | |
| Do you feel pain in any of your teeth | | |
| Do you have any sores or lumps in or near your mouth | | |
| Have you had any head, neck or jaw injuries | | |
| Have you ever experienced any of the following problems in your jaw? | | |
| Clicking | | |
| Pain (joint, ear, side of face) | | |
| Difficulty opening or closing | | |
| Difficulty chewing | | |
| Do you have frequent headaches | | |
| Do you clench or grind your teeth | | |
| Do you bite your lips or cheeks frequently | | |
| Have you noticed any loosening of your teeth | | |
| Does food tend to become caught between your teeth | | |
| Have you ever had periodontal treatment (gums) | | |
| Have you had orthodontics (braces) | | |
| Do you wear denture(s) or partial(s) | | |
| Do you like your smile | | |
| Would you like to bleach your teeth | | |

If you could change anything about your smile, what would you change?_____
_____

Signed Patient:_____ Date:_____ Reviewed by:_____