Dental History

Name: ______________________________ Date: ____________________

Primary reason for this visit: ______________________________

Other dental problems: ______________________________

How do you feel about your teeth in general? ______________________________

Rate your dental health on a scale of 0 - 10 (excellent): 0 ———— 5 ———— 10

Please answer the following by checking . . . YES or NO

	Yes	No
Have you visited the dentist regularly?	[]	[]
Do you feel nervous about having dental therapy?	[]	[]
Have you ever had an upsetting experience in a dental office?	[]	[]
Explain: ______________________________		
Is there anything else about having dental treatment that bothers you?		
Explain: ______________________________		
Habits. Do you:		
Clench or grind your teeth while awake or asleep?	[]	[]
Chew on your lips or cheeks regularly?	[]	[]
Hold foreign objects with your teeth (pencils, pens, needles, pipes, nails, or fingernails)	[]	[]
Mouth breathe while awake or asleep?	[]	[]
Do you smoke or chew tobacco?	[]	[]
Children: Thumb sucker?	[]	[]
Tongue thruster?	[]	[]
Have you ever had:		
Periodontal therapy	[]	[]
TMJ therapy	[]	[]
Your teeth ground or bite adjusted	[]	[]
Orthodontics	[]	[]
Oral surgery	[]	[]
(Circle any of the above that you feel you may need.)		
Do you have problems with teeth or fillings breaking?	[]	[]
Do you have any missing teeth?	[]	[]
Why? ______________________________		
Has anyone discussed replacements with you?	[]	[]
Do you have missing teeth replaced by a: Bridge	[]	[]
Partial	[]	[]
Implant	[]	[]
Denture	[]	[]
Are you unhappy with your dentures/partials?	[]	[]
Would you like to know more about permanent replacements?	[]	[]
Does your bite feel good?	[]	[]
Can you bite and chew well in all areas?	[]	[]

	Yes	No
Do you avoid chewing on one side? (Which? ____________)	[]	[]
Are you in any discomfort now?	[]	[]
Do you have any teeth sensitive to: Hot	[]	[]
Cold	[]	[]
Sweets	[]	[]
Do your gums feel tender or irritated?	[]	[]
Do your gums often bleed when you brush your teeth?	[]	[]
Are your gums frequently painful, swollen, or red?	[]	[]
Have you noticed any loosening of your teeth?	[]	[]
Do you feel that you have bad breath?	[]	[]
Does food tend to become caught between your teeth?	[]	[]
Have your parents experienced gum disease?	[]	[]
Do you expect to eventually lose your teeth?	[]	[]
How often do you brush? ________________ Floss? ________________		
How often do you feel you need your teeth cleaned? ________________		
Would you like us to teach you proper methods of oral health care, so you can prevent problems in your mouth?	[]	[]
Problems of the TMJ (joint). Have you experienced:		
Previous injuries to the face or jaw?	[]	[]
Whiplash or other automobile accident?	[]	[]
Clicking or popping on opening, closing, or chewing?	[]	[]
Pain in the joint, ear, side of face, or muscles?	[]	[]
Tired or sore jaw muscles?	[]	[]
Difficulty in opening or closing?	[]	[]
Pain or difficulty in chewing?	[]	[]
Frequent headaches?	[]	[]
Ear aches, stuffiness, or ringing of the ears?	[]	[]
Neck or shoulder muscle pains?	[]	[]
Are there any sores or growths in your mouth?	[]	[]
Would you like your teeth or smile to look better?	[]	[]
Can we appoint you on short notice?	[]	[]
Special requests: Gas	[]	[]
Headphones	[]	[]
Premedication to relax	[]	[]

Please rank the following in the order which they may keep you from having dental treatment:

[ ] Fear of Pain [ ] Lack of concern [ ] Cost of therapy [ ] Missing work time

How would you like to enter our practice:

[ ] Urgent Care [ ] Remedial Care [ ] Self Care [ ] Complete Dentistry [ ] Total Wellness

Name of previous dentist: ____________________ City: ____________________ State: ____________

Date of last dental visit? ____________________ Date of last cleaning? ____________

Reasons for leaving?

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