

# Dental History

|   |  |  |  |   |  |    |  |  |  |  |                                 |  |     |  |    |  |
|---|--|--|--|---|--|----|--|--|--|--|---------------------------------|--|-----|--|----|--|
| <b>Patient Name:</b>  |  |  |  | <b>Medical Alert:</b>                                     |  |    |  |  |  |  |                                 |  |     |  |    |  |
| <b><i>In order that we may provide you with the best possible care, please complete both sides of this medical dental history form. All information is completely confidential.</i></b> |  |  |  |   |  |    |  |  |  |  |                                 |  |     |  |    |  |
| What is the reason for your visit today?  |  |  |  |   |  |    |  |  |  |  |                                 |  |     |  |    |  |
|   |  |  |  |   |  |    |  |  |  |  |                                 |  |     |  |    |  |
| <b>Date of last dental visit</b>  |  |  |  | <b>What was done at your last dental visit?</b>           |  |    |  |  |  |  |                                 |  |     |  |    |  |
| <b>Last cleaning?</b>   |  |  |  |   |  |    |  |  |  |  |                                 |  |     |  |    |  |
| <b>Last Full Mouth X-rays?</b>  |  |  |  |   |  |    |  |  |  |  |                                 |  |     |  |    |  |
| Previous Dentist's Name   |  |  |  | Address:  |  |    |  |  |  |  |                                 |  |     |  |    |  |
| Telephone   |  |  |  |   |  |    |  |  |  |  |                                 |  |     |  |    |  |
| How often do you have dental examinations?  |  |  |  |   | How often do you brush your teeth?                           |    |  |  |  |  |                                 |  |     |  |    |  |
| How often do you floss?   |  |  |  |   | What other dental aids do you use? Sonicare/ toothpick/ etc. |    |  |  |  |  |                                 |  |     |  |    |  |
| <b>Please describe any dental problems you currently have:</b>  |  |  |  |   |  |    |  |  |  |  |                                 |  |     |  |    |  |
|   |  |  |  |   |  |    |  |  |  |  |                                 |  |     |  |    |  |
| <b>Are your teeth sensitive to:</b>   |  |  |  | <b>Have you ever had:</b>                                 |  |    |  |  |  |  |                                 |  |     |  |    |  |
| Hot ?   |  |  |  | Yes   |  | No |  | Orthodontic treatment?                             |  |  | Yes                             |  | No  |  |    |  |
| Cold ?  |  |  |  | Yes   |  | No |  | If yes, do you wear retainers?                     |  |  | Yes                             |  | No  |  |    |  |
| Biting or Chewing?  |  |  |  | Yes   |  | No |  | Oral surgery?                                      |  |  | Yes                             |  | No  |  |    |  |
| <b>Do you frequently get:</b>   |  |  |  | Periodontal treatment?                                    |  |    |  |  |  |  | Yes                             |  | No  |  |    |  |
| Cold sores?   |  |  |  | Yes   |  | No |  | Your bite adjusted?                                |  |  | Yes                             |  | No  |  |    |  |
| Blisters?   |  |  |  | Yes   |  | No |  | Night guard or mouth guard?                        |  |  | Yes                             |  | No  |  |    |  |
| Any oral lesions?   |  |  |  | Yes   |  | No |  | A serious injury to the mouth or head?             |  |  | Yes                             |  | No  |  |    |  |
| <b>Have you noticed any mouth odors or bad tastes?</b>  |  |  |  | If yes, please describe.                                  |  |    |  |  |  |  |                                 |  |     |  |    |  |
| Yes   |  |  |  | No  |  |    |  |  |  |  |                                 |  |     |  |    |  |
| <b>Do your gums bleed or hurt?</b>  |  |  |  | Yes   |  | No |  | <b>Have you experienced:</b>                       |  |  | Clicking or popping of the jaw? |  | Yes |  | No |  |
| Have your parents experienced gum disease or tooth loss?  |  |  |  | Yes   |  | No |  | Pain? joint/ ear/ side of face                     |  |  | Yes                             |  | No  |  |    |  |
| Have you noticed any loose teeth or change in your bite?  |  |  |  | Yes   |  | No |  | Difficulty in opening or closing the mouth?        |  |  | Yes                             |  | No  |  |    |  |
| Does food tend to become caught in between your teeth?  |  |  |  | Yes   |  | No |  | Difficulty in chewing on either side of the mouth? |  |  | Yes                             |  | No  |  |    |  |
| If yes, where?  |  |  |  | Headaches, neckaches or shoulder aches?                   |  |    |  |  |  |  | Yes                             |  | No  |  |    |  |
|   |  |  |  | Sore muscles in your neck or shoulders?                   |  |    |  |  |  |  | Yes                             |  | No  |  |    |  |
| <b>Do you:</b>  |  |  |  | <b>Do you feel nervous about having dental treatment?</b> |  |    |  |  |  |  |                                 |  |     |  |    |  |
| Clench or grind your teeth while awake or asleep?   |  |  |  | Yes   |  | No |  | If so, what is your biggest concern?               |  |  |                                 |  |     |  |    |  |
| Bite your cheeks or lips frequently?  |  |  |  | Yes   |  | No |  |  |  |  |                                 |  |     |  |    |  |
| Hold objects with your teeth: pencils/pens/pins/pipe  |  |  |  | Yes   |  | No |  |  |  |  |                                 |  |     |  |    |  |
| Bite your fingernails?  |  |  |  | Yes   |  | No |  | Have you ever had an upsetting dental experience?  |  |  |                                 |  |     |  |    |  |
| Mouth breathe while awake or asleep?  |  |  |  | Yes   |  | No |  | If so, please explain                              |  |  |                                 |  |     |  |    |  |
| Have tired jaws especially in the morning?  |  |  |  | Yes   |  | No |  |  |  |  |                                 |  |     |  |    |  |
| Smoke or chew tobacco?  |  |  |  | Yes   |  | No |  |  |  |  |                                 |  |     |  |    |  |
|   |  |  |  |   |  |    |  |  |  |  |                                 |  |     |  |    |  |
| <b>Are you satisfied with the appearance of your teeth?</b>   |  |  |  | If not, what would you change?                            |  |    |  |  |  |  |                                 |  |     |  |    |  |
| <b>Are you interested in using sedation for your appointments?</b>  |  |  |  |   |  |    |  |  |  |  |                                 |  |     |  |    |  |
| <b>Is there anything else about having dental treatment that you would like us to know?</b>   |  |  |  |   |  |    |  |  |  |  |                                 |  |     |  |    |  |
| If so, please explain   |  |  |  |   |  |    |  |  |  |  |                                 |  |     |  |    |  |

PLEASE COMPLETE OTHER SIDE