

# DENTAL HISTORY

Patient Name: \_\_\_\_\_ Medical Alert: \_\_\_\_\_

*Welcome! So that we may provide you with the best possible care  
please complete this medical/dental history form. All information is completely confidential.*

What is the reason for your visit today? \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Mouth X-rays \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_

Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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? (Interplak, toothpick, etc.) \_\_\_\_\_

**Are any of your teeth sensitive to:**

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or  
any other oral lesions? Yes No

**Do your gums bleed or hurt?** Yes No

Have your parents experienced gum disease  
or tooth loss? Yes No

Have you noticed any loose teeth or change in  
your bite? Yes No

Does food tend to become caught in between  
your teeth? Yes No

If yes, where? \_\_\_\_\_

**Do you:**

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth?  
(pencils, pipe, pins, nails, fingernails) Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Snore or have any other sleeping disorders? Yes No

Smoke/chew tobacco or use other tobacco  
products? Yes No

**Have you ever had orthodontic treatment?** Yes No

How long ago? Yes No

Have you had movement in your teeth since? Yes No

**Have you ever had periodontal treatment?** Yes No

If so, when? \_\_\_\_\_

If so, what kind? \_\_\_\_\_

**Have you ever had:**

Oral Surgery? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause \_\_\_\_\_

**Have you experienced:**

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neckaches, or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

**Do you wear dentures/partials?** Yes No

Do they fit well? Yes No

Do you have trouble chewing? Yes No

Do you use adhesive? Yes No

**Are you satisfied with your teeths appearance?** Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? \_\_\_\_\_

If so, what is your biggest concern? \_\_\_\_\_

Have you ever had an upsetting dental experience? Yes No

If yes, please describe \_\_\_\_\_

If no, what don't you like? \_\_\_\_\_

**Have you whitened your teeth before?** Yes No

If yes, how? \_\_\_\_\_

What would you change about your smile if you could? \_\_\_\_\_