DENTAL HISTORY

Patient Name:	PID:	Date:

MEDICAL ALERT	Condition:	Premedication:

Are you experiencing any dental problems?	Yes ☐ No ☐
Date of your last dental visit:	
Dental cleaning:	
X-rays:	

		YES	NO
1.	Have you been seeing a dentist regularly?	☐	☐
2.	Are there any growths or sore spots in your mouth?	☐	☐
3.	Have you noticed any loose teeth, or have any of your teeth shifted?	☐	☐
4.	Does food get caught between your teeth?	☐	☐
5.	Are any of your teeth sensitive to heat, cold, sweets or pressure?	☐	☐
6.	Have you been advised to take antibiotics before a dental appointment?	☐	☐
7.	Do you use dental floss, proxabrush, or stimudents?	☐	☐
	How often?		
8.	How often do you brush your teeth?		
	- Do you feel that you have bad breath?	☐	☐
9.	Have you ever had one of the following?		
	- Periodontal treatment? (treatment of the gums)	☐	☐
	- Orthodontic treatment? (to straighten or realign teeth)	☐	☐
	- A bite plate or any other appliance?	☐	☐
	- Your bite adjusted or teeth ground?	☐	☐
	- Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?)	☐	☐
10.	JAW PROBLEMS - Do you have any of the following?		
	- Popping/clicking in your jaw joints?	☐	☐
	- Pain in your jaw joints, around your ear, or side of your face?	☐	☐

	- Difficulty in opening or closing?	☐	☐
	- Pain when teeth are clenched?	☐	☐
	- Pain/difficulty in chewing?	☐	☐
11.	Do you have any of the following habits?		
	- Clenching or grinding your teeth while awake or asleep?	☐	☐
	- Biting your cheeks or lips regularly?	☐	☐
	- Breathing through your mouth while awake or asleep?	☐	☐
	- Hold foreign objects with your teeth (pencils, nails, pipes, pins, fingernails)?	☐	☐
12.	Do you have any emotional concerns about having dental treatment?	☐	☐
13.	Are you happy with the appearance of your teeth?	☐	☐
	If no, what would you like to see changed?		
14.	Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or do you have any questions or concerns?	☐	☐