DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN / WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO
HX OF TRAUMA TO FACE/TEETH	☐	☐
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	☐	☐
DO YOU FEEL PAIN TO 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 YOUR EVER EXPERIENCES ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH	☐	☐

	YES	NO
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 YOUR EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE	☐	☐
HAVE YOUR EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	☐	☐
HAVE YOUR EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT _____		
HAVE YOUR EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	☐	☐
REGULAR USE OF COUGH DROPS	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

_____

_____

SOCIAL

Tobacco use (Cigarette, Cigar, Pipe, Chewing Tobacco, Snuff _____ Amount / Day? _____

Start Year _____ Length of Time _____

Occupation _____

Have you ever worked in the health care field with patients, blood products, saliva, or other body fluids? _____

Country of Origin _____

Do you or have you ever had a drug or alcohol abuse problem? If yes, what drugs _____

Have you or your sexual partners used intravenous drugs? _____

If Yes, did you or do you share needles? _____

How many alcoholic drinks do you have each day? _____

DOCTOR'S COMMENTS _____

_____

_____

_____