

DENTAL HISTORY

Name: _____

1. How long since your last dental appointment? _____
What was done? _____
Why did you change dental offices? _____

2. Anything about dental visits that particularly bothers you? _____

3. What concerns might keep you or have kept you in the past from having dental treatment completed?

- (Check any that apply)
- ___ Fear or anxiety regarding treatment
 - ___ Cost of dental treatment
 - ___ Missing work time or too busy
 - ___ Don't care much about my teeth
 - ___ Lack of trust in the dentist
 - ___ Other _____

4. Do you now or have you ever had any of the following? (Check any that apply)

- | | |
|---|--|
| ___ Frequent headaches | ___ Teeth shifting or moving |
| ___ Muscle soreness in your head or neck | ___ Teeth sensitive to ___ Hot ___ Cold ___ Sweets |
| ___ Difficulty in opening or closing you jaw | ___ Teeth sensitive to biting |
| ___ Clicking or popping noise in your jaw joint | ___ Worn teeth |
| ___ Injury to your jaw or face | ___ Loose teeth |
| ___ Pain or discomfort in your jaw joint | ___ Broken teeth |
| ___ Jaw locking open or closed | ___ Do you clench or grind teeth |
| ___ Changes in your bite | ___ Sore teeth or jaw muscles in the morning |

5. Do your gums ever bleed? ___ Yes ___ No

Have you been treated for gum disease? ___ Yes ___ No

Any areas where food catches between your teeth? ___ Yes ___ No

How often do you brush? _____ Floss? _____

6. ___ Yes ___ No Any lumps or swelling in your head, neck, or mouth?

___ Yes ___ No Have you had orthodontics (Braces) if yes, how long ago? _____

___ Yes ___ No Do you still have wisdom teeth?

___ Yes ___ No Do you have missing teeth besides wisdom teeth?

___ Yes ___ No Do you have a denture or partial denture? If yes, how old is it? _____

7. If you could change anything about your smile, what would it be? _____

8. ___ Yes ___ No Is keeping your teeth for a lifetime important to you?

___ Yes ___ No Have you had regular cleaning appointments in the past?

___ Yes ___ No Have you followed through with recommended dental treatment in the past?

___ Yes ___ No Do you strive to have a healthy lifestyle through proper nutrition and exercise?

___ Yes ___ No Do you smoke or use chewing tobacco?

9. My present state of oral health is: ___ Excellent ___ Good ___ Poor
I would like my level of oral health to be: ___ Excellent ___ Good ___ Don't really care

10. What is your **main** dental concern or problem at this time? _____

(OFFICE USE ONLY) Pertinent dental history _____