

PATIENT DENTAL HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

1. What is your present dental concern? \_\_\_\_\_ Services Desired \_\_\_\_\_
2. Please describe your general dental health \_\_\_\_\_
3. How long since your last dental visit? \_\_\_\_\_ Former Dentist \_\_\_\_\_  
NAME CITY STATE
4. How long since your last cleaning visit? \_\_\_\_\_
5. Have you had a complete set of dental x-rays (about 16 films), taken within the last two years? YES NO
6. Do you think you have active decay or gum disease? \_\_\_\_\_ YES NO
7. Are you worried about receiving dental treatment? \_\_\_\_\_ YES NO
8. Have you ever had an unusual reaction or problem with dental anesthetic or treatment? \_\_\_\_\_ YES NO
9. How often do you brush \_\_\_\_\_ Brush Type:  SOFT  MED  HARD. Do you use fluoride toothpaste? YES NO
10. How often do you floss \_\_\_\_\_ What other oral homecare products/devices do you use? \_\_\_\_\_  
 \_\_\_\_\_
11. Has plaque removal between teeth, and above and below the gumline been emphasized and demonstrated to you with brush, floss, stimulents or other devices? \_\_\_\_\_ YES NO
12. Is there anything you would change about the appearance of your teeth? \_\_\_\_\_ YES NO
13. Are you missing any teeth? \_\_\_\_\_ YES NO  
 Have they been replaced by bridges, partials, or dentures? \_\_\_\_\_ YES NO
14. Do your gums bleed while brushing or flossing? \_\_\_\_\_ YES NO
15. Does food pack between any teeth? \_\_\_\_\_ YES NO
16. Are any teeth sensitive to hot, cold, sweets, or pressure? \_\_\_\_\_ YES NO
17. Do you have a regular high sugar consumption habit (pop, hard candy, mints, etc.)? \_\_\_\_\_ YES NO
18. Do you chew gum or hard objects such as ice, popcorn kernels, etc.? \_\_\_\_\_ YES NO
19. Do you ever have popping, clicking, or discomfort in your jaw joint (TMJ)? \_\_\_\_\_ YES NO
20. Are you aware of clenching or grinding your teeth during the day or night? \_\_\_\_\_ YES NO
21. Do you have frequent headaches? \_\_\_\_\_ YES NO
22. Do you or have you ever worn a nightguard? \_\_\_\_\_ YES NO
23. Do you have or have you ever had slow healing sores or growths in your mouth? \_\_\_\_\_ YES NO
24. Circle any of the following concerns you have about your mouth, teeth, or gums:
 

Bad Breath	Spaces	Periodontitis	Discolored Fillings
Bad Taste	Infection	Loose Teeth	Smile
Missing Teeth	Swollen Gums	Shifting Teeth	Gag Easily
Broken Teeth	Red Gums	Appearance	Crooked Teeth
Old Fillings	Bleeding Gums	Bad Bite	Other _____
Broken Fillings	Gingivitis	Dark Teeth	
25. How important is it to you to keep your existing natural teeth the rest of your life? \_\_\_\_\_
26. CHILDREN TO AGE 14 YEARS:
  - Is your current drinking water fluoridated? \_\_\_\_\_ UNKNOWN YES NO
  - Is your child taking supplemental fluoride tablets/drops? \_\_\_\_\_ UNKNOWN YES NO
  - In the past, has your child had fluoridated water or supplemental fluoride tablets/drops? \_\_\_\_\_ UNKNOWN YES NO
  - Have your child's permanent molars been sealed? \_\_\_\_\_ UNKNOWN YES NO
  - Does your child have any oral habits such as thumb sucking, lip biting, mouth breathing, tongue thrusting when swallowing, etc.? \_\_\_\_\_ UNKNOWN YES NO

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_