Dental History

Previous Dentists Name:_____When was your last dental exam? _____

What was done?_____Date of last x-rays?_____

Any issues with the treatment or experience?_____

Are there any treatment(s) that has been recommended that hasn't been done?_____

Is there anything bothering you today?_____
How long has it bothered you?_____

How do you take care of your teeth at home? (Circle all that apply) Brush Floss Rinse

Do you use a soft toothbrush? _____ Do your gums bleed after brushing/flossing? _____

Have you ever had professional instruction on home care?_____

Do you visit the dentist regularly?_____

Have you noticed bad breath or an unpleasant taste in your mouth? _____

Do your teeth ever bother you from sweets? _____Hot/Cold _____

Have you ever had noticed any swelling, lumps, or red areas in your mouth or throat that haven't seemed to go away? _____

_____

Are there any dental diseases in your family? _____

How do you feel about your teeth? _____

Do you like the way they look? _____

Is there anything you would like to change about them?_____

Can you chew on both sides? _____ Do you have trouble with food catching between your teeth?_____

Do you grind or clench your teeth?_____ Does your jaw hurt when you wake up? _____

Does your jaw make noise when you chew? _____Do you have a TMJ specialist?_____

Do you have removable appliances in your mouth? _____

Do you smoke?_____ Amount per Day_____ Drink Coffee?_____ Amount per day_____

Tea?_____ Amount per day _____ Soft Drinks?_____Amount per day_____ Gum?_____ Frequency_____

Do you feel you have had a lot of dental treatment in the past?_____

Are you satisfied with your past treatment? _____Have you had your wisdom teeth removed?_____

Have you had orthodontic treatment?_____Have you ever had a root canal? _____

Has anyone told you that you had periodontal disease, bone loss, recession or gum problems?_____

What would you like me to do for you?_____