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Dental History

Name _____ Date _____
First Mi. Last

Reason for Today's Visit _____

Date of last exam _____ Date of last dental X-rays _____

Date of your last dental cleaning _____ How often do you brush? _____

What type of toothbrush do you use? □ regular □ electric

How often do you floss? _____

Do you use mouthwash or some other type of rinse? □ Yes □ No Describe _____

Do you have any dental problems now? □ Yes □ No Describe _____

_____

Have you ever had an upsetting dental experience? □ Yes □ No Describe _____

_____

Have you ever had: □ Orthodontics □ Periodontal Surgery □ Oral Surgery

Please check any of the following conditions that apply to you:

□ Bad Breath
□ Bleeding Gums
□ Clicking or Popping jaw
□ Food Collection between Teeth
□ Tired jaws in the morning
□ Difficulty in opening or closing the mouth
□ Grinding Teeth
□ Loose Teeth or Broken Filling
□ Periodontal Treatment
□ Sores or Growths in Your Mouth
□ Sore Facial Muscles
□ Sensitivity to Hot
□ Sensitivity to Cold
□ Sensitivity When Biting
□ Sensitivity to Sweets
□ Wear a Night Guard
□ Headaches or Neck Aches
□ Snoring

Are you happy with the appearance of your teeth? □ Yes □ No If no, please describe

_____

□ Other: _____

_____

Previous Dentist's Name _____