# DENTAL HISTORY

| Name | Date of Last Dental Visit | Date of Last Dental Cleaning | Date of Last Full Mouth series of X-rays |
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Chief dental complaint (reason for your appointment today):

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So that we can become familiar with your dental health, please answer the questions below to the best of your ability.

1. Are you having any pain at this time? ..... Yes No
2. PREVIOUS DENTAL TREATMENT:
   a. Periodontal Treatment? ..... Yes No
   b. Oral Surgery? ..... Yes No
   c. Orthodontic Treatment? ..... Yes No
   d. Your teeth ground or bite adjusted? ..... Yes No
3. APPLIANCES
   a. Are you wearing a temporary? ..... Yes No
   b. Are you wearing a removable denture? ..... Yes No
   c. Do you wear a bite guard? ..... Yes No
   d. Do you use a sleep appliance? ..... Yes No
4. Have you noticed your teeth loosening? ..... Yes No
5. Does food tend to become caught between your teeth? ..... Yes No
6. Do you suffer from pain and/or swelling of your gums? ..... Yes No
7. Do your gums often bleed when you brush your teeth? ..... Yes No
8. PROBLEMS OF THE JAW:
   a. Clicking of the jaw? ..... Yes No
   b. Pain (Joint, ear, side of face)? ..... Yes No
   c. Difficulty in opening or closing? ..... Yes No
   d. Difficulty in chewing? ..... Yes No

8. HABITS:
   a. Clench or grind your teeth while awake? ..... Yes No
   b. Clench or grind your teeth while asleep? ..... Yes No
   c. Bite your lips or cheeks regularly? ..... Yes No
   d. Mouth breath while awake or asleep? ..... Yes No
   e. Hold foreign objects with your teeth (such as pencils, pipe, pins, fingernails)? ..... Yes No
9. Do you get frequent cold sores or fever blisters? ..... Yes No
10. Do you feel nervous about having dental treatment? ..... Yes No
11. Have you ever had an upsetting experience in a dental office? ..... Yes No
12. Is it important to you to keep your teeth? ..... Yes No
13. Are you dissatisfied with the appearance of your teeth? ..... Yes No
14. Is there anything else about having dental treatment that bothers you? ..... Yes No

EXPLANATION:

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