Dental history

Patient's name : _____

1. Reason for today's visit? _____
2. Are you aware of any problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's Name : _____
6. When was the last time your teeth were cleaned? _____

Select the Appropriate Answer.

7. Have you made regular dental visits? ☐ Yes ☐ No ☐ Dont Know
8. Were dental x-rays taken? ☐ Yes ☐ No ☐ Dont Know
9. Have you lost any teeth or have any teeth been removed? ☐ Yes ☐ No ☐ Dont Know
   Why? _____
10. Have they been replaced? ☐ Yes ☐ No ☐ Dont Know
11. How have they been replaced?
    a. ☐ Fixed Bridge When? _____
    b. ☐ Removable Bridge When? _____
    c. ☐ Denture When? _____
    d. ☐ Implant When? _____
12. Are you happy with the replacement? ☐ Yes ☐ No ☐ Dont Know
    If not, explain? _____
13. Would you like to know about permanent replacements? ☐ Yes ☐ No ☐ Dont Know
14. Have you ever had any problems or complications with previous dental treatment?
15. Do you clench or grind your teeth? ☐ Yes ☐ No ☐ Dont Know
16. Does your jaw pop or click? ☐ Yes ☐ No ☐ Dont Know
17. Have you experienced any pain or soreness in the muscles in your face or around your ear? ☐ Yes ☐ No ☐ Dont Know
18. Do you have frequent headaches, neckaches or shoulder aches? ☐ Yes ☐ No ☐ Dont Know
19. Does food get caught in your teeth? ☐ Yes ☐ No ☐ Dont Know
20. Are any of your teeth sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure
21. Do your gums bleed or hurt? When? _____ ☐ Yes ☐ No ☐ Dont Know
22. Have you ever had gum treatment or surgery? ☐ Yes ☐ No ☐ Dont Know
    What? _____
    When? _____
    Where? _____
23. Do you feel your breath is offensive at times? ☐ Yes ☐ No ☐ Dont Know
24. How often do you brush your teeth daily? ☐ 1x ☐ 2x ☐ 3x ☐ more
25. Do you use dental floss? ☐ Yes ☐ No ☐ Dont Know
    How often? _____
26. Are any of your teeth: ☐ Loose ☐ Tipped ☐ Shifted ☐ Chipped
27. Are you happy with the appearance of your teeth? ☐ Yes ☐ No ☐ Dont Know
28. How do you feel about your teeth in general? _____
29. Have you had orthodontic work? ☐ Yes ☐ No ☐ Dont Know
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?
31. Do you have any questions or concerns? ☐ Yes ☐ No ☐ Dont Know

COMMENTS: OFFICE USE

☐ **I certify that the above information is complete and accurate.**

Patient's / Guardian's signature : _____ Date : _____

Dentist's Signature : _____ Date : _____