



Dental History Form

Name _____

Date _____

Reason for today's visit _____ _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth or clenching <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____

When was your last set of full mouth radiographs? 18 individual x-rays or panorex film
(large film that shows all of your teeth) _____

How often do you get your teeth cleaned? _____

Have you had serious troubles with any previous dental treatment? Yes or No

If yes, please explain _____

What did you like most about your previous dental office? _____

What did you like least about your previous dental office? _____

Do you wear a night guard? _____ Appliance? _____ Removable denture? _____

If you have missing teeth, what was the cause? (decay, gum disease, trauma?) _____

How important is it to retain your teeth all of your life? _____

What toothpaste do you use? _____ frequency? _____

What mouth rinse do you use? _____ frequency? _____

Have you ever had teeth removed? _____ If so, was a local anesthetic (needle) used or was general anesthesia (put to sleep)
used? _____ Which do you prefer? _____

If you have had teeth removed, has it ever been recommended to replace them? _____

Do you want all the details about necessary treatment or just an overview? _____

Are you satisfied with the appearance of your teeth, gums, and your smile? Yes or No

Would you like to discuss enhancing the appearance of your smile? Yes or No

Would you like to discuss how to make your teeth white(r)? _____

Do you have old fillings or other dental work that you aren't happy with that you want to replaced? _____

Does your jaw get stuck, locked or go out? Yes or No Has your jaw, head, or neck ever been injured? Yes or No

Have you ever been treated for a TMJ problem? Yes or No If yes, please circle the following that apply:

Bite Splint, Medication, Surgery, Orthodontics, Physical Therapy, Equilibration, Counseling

What are your short, medium, and long term goals for your mouth and teeth?

Short _____

Medium _____

Long _____

Please circle the #1 barrier you have to dental care: money, time, pain, fear (of what?) _____

Examples are: Needles, noise, smell, invasion of personal space.