## Dental History

Name_____
Previous Dentist_____ Period of treatment_____
Address_____ Specialty_____
Last dental visit_____ Last full-mouth X-ray_____
Last complete dental exam_____
What is your immediate dental concern? _____

Please check **YES** or **NO** for the following questions

| YES | NO | |
|---|---|---|
| ____ | ____ | Are you presently in any dental pain?_____ |
| ____ | ____ | Is any part of your mouth sensitive to temperature, pressure, food or drink? |
| ____ | ____ | Have you ever experienced any unfavorable reaction to dentistry? |
| ____ | ____ | Have you ever had a bad reaction to a dental anesthetic? When?_____ |
| ____ | ____ | Do you have any growths or swelling in your mouth? How long?_____ |
| ____ | ____ | Do you have any difficulty in swallowing? |
| ____ | ____ | Do you have a dry or burning sensation in your mouth? |
| ____ | ____ | Do your gums bleed when brushing your teeth? |
| ____ | ____ | Do you avoid brushing any part of your mouth? |
| ____ | ____ | Have you ever been told you had gum disease or gingivitis? When?_____ |
| ____ | ____ | Does food catch between your teeth?_____ |
| ____ | ____ | Do you have an unpleasant taste or odor in your mouth? |
| ____ | ____ | Do you have any pain or soreness around your eyes, ears or other parts of your face? |
| ____ | ____ | Are you aware of stiff neck muscles? How often?_____ |
| ____ | ____ | Do you ever awaken with an awareness of your teeth or jaws? How often?_____ |
| ____ | ____ | Are you aware of clenching your teeth during the day? |
| ____ | ____ | Have you been told you grind your teeth at night? |
| ____ | ____ | Are you aware of clicking or popping in your jaw while eating or yawning? |
| ____ | ____ | Do you have difficulty in opening your mouth widely? |
| ____ | ____ | Do you have 'tension' headaches? How often?_____ |
| ____ | ____ | Have you lost any teeth? From what cause?_____ |
| ____ | ____ | Do any members of your family had dentures?_____ |
| ____ | ____ | Do you feel you will eventually wear full dentures? |
| ____ | ____ | Are you dissatisfied with you're the appearance of your teeth? |
| ____ | ____ | Have you ever had orthodontic treatment? |
| ____ | ____ | Do you think your dental disease is active? |
| ____ | ____ | Do you want to learn to control your dental disease and retain your teeth? |
| ____ | ____ | Are you deeply concerned about the finances required to return your mouth to excellent dental health? |

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