DENTAL HISTORY

Reason for visit today? ____________________

Date of: Last Dental Visit ____________ Last Dental Cleaning ____________ Last Full Mouth X-rays ____________

What was done at your last dental visit? ____________________

Previous Dentist's Name: ____________________ Phone: ____________

Address: ____________________

How often do you have dental examinations? ____________ How often do you brush your teeth? ____________

How often do you floss? ____________ What dental aids do you use? (Proxybrush, rinses, etc.) ____________

Are any of your teeth sensitive to:
- Hot or cold? ☐ Yes ☐ No
- Sweets? ☐ Yes ☐ No
- Biting or chewing? ☐ Yes ☐ No

Do you notice any mouth odor or bad taste? ☐ Yes ☐ No

Do you frequently get cold sores, blisters or any other oral lesions? ☐ Yes ☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No

Have your parents experienced gum disease or tooth loss? ☐ Yes ☐ No

Have you noticed any loose teeth or change in your bite? ☐ Yes ☐ No

Does food tend to become caught in your teeth? If yes, where ____________ ☐ Yes ☐ No

Do you:
- Clench or grind your teeth while awake? ☐ Yes ☐ No
- Clench or grind your teeth while you sleep? ☐ Yes ☐ No
- Bite your lips or cheeks regularly? ☐ Yes ☐ No
- Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) ☐ Yes ☐ No
- Mouth breathe while awake or asleep? ☐ Yes ☐ No
- Have tired jaws, especially in the morning? ☐ Yes ☐ No

Have you ever had:
- Orthodontic treatment? ☐ Yes ☐ No
- Oral surgery? ☐ Yes ☐ No
- Periodontal treatment? ☐ Yes ☐ No
- Your teeth ground or the bite adjusted? ☐ Yes ☐ No
- A bite plate or mouth guard? ☐ Yes ☐ No
- A serious injury to the mouth? ☐ Yes ☐ No

If yes, describe ____________

Have you ever experienced:
- Clicking or popping of the jaw? ☐ Yes ☐ No
- Joint, ear or side of face pain? ☐ Yes ☐ No
- Difficulty in closing mouth? ☐ Yes ☐ No
- Headaches, neck aches or shoulder aches? ☐ Yes ☐ No
- Sore muscles? (neck or shoulders) ☐ Yes ☐ No

Are you satisfied with your teeth's appearance? ☐ Yes ☐ No

Would you like to keep all of your teeth, all of your life? ☐ Yes ☐ No

Do you feel nervous about having dental treatment? ☐ Yes ☐ No
If so, what is your biggest concern?
____

Have you ever had an upsetting dental experience? ☐ Yes ☐ No
If so, please describe
____

Is there anything else about having dental treatment that you would like us to know? ____________

____

____

FOR OFFICE USE ONLY

Reviewed by: ____________________ Date: ____________
(staff signature)

DENMARK DENTISTRY