NAME:_____ Date:_____

DENTAL HISTORY

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Mouth ulcers or cold sores
- ☐ Broken tooth or fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth
- ☐ Insomnia
- ☐ Sleep apnea
- ☐ Nasal oxygen use

Have you or any family members had any of the following?

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments
- ☐ History of heart disease
- ☐ History of diabetes

Please share the following dates:

Your last cleaning:_____
Your last oral cancer screening:_____
Your last complete x-rays:_____
Your last periodontal screening:_____

Why did you leave your previous dentist?

_____

Do you smoke or use chewing tobacco? How much? For how long?

_____

If you could whiten your smile for $1 a day, would you like to?

_____

If you could change your smile, you would:

- ☐ Make my teeth brighter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with natural, tooth-colored fillings
- ☐ Replace chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that do not match
- ☐ Have a smile makeover

What is the most important thing to you about your dental visit today?

_____

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?

1

Where would you rate your current dental health?

1

What is the most important thing to you about your future smile and dental health?

_____
_____
_____