Dental History

Patient's Name:

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
- ○ Do you have trouble falling asleep?
- ○ Do you have trouble staying asleep?
- ○ Trouble sleeping or difficulty staying asleep
- ○ 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?

_____

Date:

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

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

_____

On a scale of A-D with A being the highest rating:

How important is your dental health to you?

A B C D

Where would you rate your current dental health?

A B C D

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

_____
_____
_____

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