

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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Dental History

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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