

# DENTAL HISTORY

Chief complaint or purpose of this appointment? \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last full mouth x-rays \_\_\_\_\_

Date of last dental cleaning \_\_\_\_\_ Name of Previous Dentist \_\_\_\_\_

	YES	NO
Do you think you have decayed teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>
Are any of your teeth sensitive to: <input type="checkbox"/> Heat <input type="checkbox"/> Cold <input type="checkbox"/> Sweets <input type="checkbox"/> Pressure If yes, where? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when brushing?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an unpleasant odor or taste in your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do any of your teeth seem loose?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pains of the face or jaws? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer with headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced clenching or grinding your teeth while awake or asleep? .....	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, where? _____		
Do you avoid one side when chewing? <input type="checkbox"/> Left or <input type="checkbox"/> Right	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any teeth removed?.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, for what reason? _____		
If you now wear complete or partial dentures, do you have trouble with them?.	<input type="checkbox"/>	<input type="checkbox"/>
Have you worn braces for straightening your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew gum or suck any kind of mints regularly? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a toothbrush with: <input type="checkbox"/> Soft <input type="checkbox"/> Medium <input type="checkbox"/> Hard Bristles?		
Do you use dental aids such as: <input type="checkbox"/> tooth picks <input type="checkbox"/> dental floss <input type="checkbox"/> irrigation sprays	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been taught to control dental disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do dental treatments cause you much concern, worry, or tension? .....	<input type="checkbox"/>	<input type="checkbox"/>
In the past have you had the opportunity to choose your dental treatment? If so, what was your choice: <input type="checkbox"/> Gold <input type="checkbox"/> Porcelain <input type="checkbox"/> Silver	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS \_\_\_\_\_