

DENTAL HISTORY

Date _____
Day month year

PATIENT NAME		WISHES TO BE CALLED	
LAST DENTAL VISIT	LAST DENTAL CLEANING	LAST FULL MOUTH SERIES OF X-RAYS	
_____ <small>day month year</small>	_____ <small>day month year</small>	_____ <small>day month year</small>	

INITIAL CONCERN _____

SHORT TERM & LONG TERM GOALS/WISHES _____

1. YES NO Are you having pain at this time? Describe: _____

2. Have you ever had any of the following:
 - a. YES NO Orthodontic treatment (e.g. braces)?
 - b. YES NO Oral surgery (e.g. teeth removed)?
 - c. YES NO Periodontal treatment (e.g. gum therapy)?
 - d. YES NO Your teeth ground or the bite adjusted?
 - e. YES NO Worn a bite plate or other appliance?

3. YES NO Have you noticed any loosening of your teeth?

4. YES NO Does food tend to become caught between your teeth? Where? _____

5. YES NO Do you suffer from pain and/or swelling of your gums?

6. YES NO Do your gums often bleed when you brush your teeth?

7. Problems of the Jaw. Have you experienced:
 - a. YES NO Clicking of the jaw?
 - b. YES NO Pain (joint, ear, side of face)?
 - c. YES NO Difficulty in opening or closing?
 - d. YES NO Difficulty in chewing?

8. Habits. Do you:
 - a. YES NO Clench your jaw? AWAKE ASLEEP
 - b. YES NO Grind your teeth? AWAKE ASLEEP
 - c. YES NO Bite your lips or cheeks regularly?
 - d. YES NO Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails?)
 - e. YES NO Mouth breathe? AWAKE ASLEEP

9. YES NO Is it important to keep your teeth?

10. YES NO Are you dissatisfied with the appearance of your teeth? _____

11. 1 2 3 4 How comfortable do you feel about having dental treatment?
 (Where 1 is calm and 4 is very afraid)

12. YES NO Have you ever had an upsetting experience in a dental office?

13. YES NO Is there anything else about having dental treatment that bothers you? Explain.
