



DENTALHISTORY

Patient's Name: _____
Last First Initial Date of Birth

COMMENTS₁

- 1. Purpose of your initial visit? _____
- 2. Are you aware of any problems? _____

- 3. How long since your last dental visit? _____
- 4. Previous dentist's name _____ City _____
- 5. When was the last time your teeth were professionally cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DO NOT KNOW THE CORRECT ANSWER, PLEASE WRITE "DO NOT KNOW" ON THE LINE AFTER THE QUESTION.

- 6. Did you make regular visits to the dentist? YES NO
How often? _____
- 7. Have you ever had any of the following procedures?
a. Fixed bridge _____
b. Removable partial denture _____
c. Denture _____
d. Implant _____
- 8. Are you unhappy with any of the above treatments? YES NO If
yes, explain _____
- 9. Would you like to know about other options in treatment? YES NO 10.
Have you ever had any problems or complications with previous dental treatment? . .
. YES NO
If yes, explain _____
- 11. Do you clench or grind your teeth? YES NO
- 12. Does your jaw click or pop? YES NO
- 13. Have you ever experienced any pain or soreness in the muscles of your face or around
your ear? YES NO
- 14. Do you have frequent headaches or neck and shoulder aches? YES NO
- 15. Are any of your teeth sensitive to: Hot? Cold? Pressure? Sweets?
- 16. Do your gums bleed or hurt? YES NO
- 17. How often do you brush your teeth? _____
- 18. How often do you use dental floss? _____
- 19. Are any of your teeth loose, tipped, shifted or chipped? YES NO
- 20. Are you unhappy with the appearance of your teeth? YES NO 21.
How do you feel about your teeth in general? _____

- 22. Do you feel your breathe is offensive at times? YES NO
- 23. Have you ever had gum treatment or surgery? YES NO
- 24. Have you had any orthodontic work? _____
- 25. Have you had any unpleasant dental experiences or is there anything about dentistry
that you strongly dislike? _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.
PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____
DENTIST'S SIGNATURE _____ DATE _____