

# DENTAL HISTORY

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of last dental visit? \_\_\_\_\_ Last dental cleaning \_\_\_\_\_ Last Full Mouth X-rays \_\_\_\_\_

Previous Dentist Name \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

How often do you have your dental examination? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What other dental aids do you use? (Sonicare, Braun, toothpick, proxybrush, endtuft, etc. ) \_\_\_\_\_

Do you have active dental problems now? \_\_\_\_\_ Yes No \_\_\_\_\_

Gum disease? \_\_\_\_\_ Yes No \_\_\_\_\_

Bleeding gums \_\_\_\_\_ Yes No \_\_\_\_\_

Decay? \_\_\_\_\_ Yes No \_\_\_\_\_

Broken teeth \_\_\_\_\_ Yes No \_\_\_\_\_

Do you have trouble with bad breath? \_\_\_\_\_ Yes No \_\_\_\_\_

Do you have any loose teeth? \_\_\_\_\_ Yes No \_\_\_\_\_

Where? \_\_\_\_\_

## Have you ever had:

Orthodontics treatment? \_\_\_\_\_ Yes No \_\_\_\_\_

Oral surgery or teeth removed? \_\_\_\_\_ Yes No \_\_\_\_\_

Periodontal treatment? \_\_\_\_\_ Yes No \_\_\_\_\_

Endodontic treatment? \_\_\_\_\_ Yes No \_\_\_\_\_

Your teeth ground or the bite adjusted? \_\_\_\_\_ Yes No \_\_\_\_\_

Have you ever had general anesthesia? \_\_\_\_\_ Yes No \_\_\_\_\_

Having had broken jaw? \_\_\_\_\_ Yes No \_\_\_\_\_

Missing back teeth with no replacement? \_\_\_\_\_ Yes No \_\_\_\_\_

Have you ever had cortisone injected into joints \_\_\_\_\_ Yes No \_\_\_\_\_

If yes, when? \_\_\_\_\_ How many injections? \_\_\_\_\_

By whom? \_\_\_\_\_

A bite plate, splint or mouth guard? \_\_\_\_\_ Yes No \_\_\_\_\_

If so please describe cause \_\_\_\_\_

## OCCLUSAL HABITS

### Do you:

\_\_\_ Clench or grind your teeth? \_\_\_\_\_ AM PM \_\_\_\_\_

\_\_\_ Teeth hit in front first

\_\_\_ Cheek Biting

\_\_\_ Pipe Smoking

\_\_\_ Nail Biting

\_\_\_ Have previous dentists have difficulty in getting you numb?

\_\_\_ Have tired jaws, especially in the morning?

\_\_\_ Gum Chewing

\_\_\_ Pencil Biting

\_\_\_ Other \_\_\_\_\_

### Are any of your teeth sensitive to:

\_\_\_ Hot or cold?

\_\_\_ Biting or chewing

\_\_\_ Cold sores, blisters, or any other oral lesions?

\_\_\_ Sweets?

\_\_\_ Have you noticed any mouth odors or bad tastes?

\_\_\_ Have you experienced gum disease or tooth loss?

\_\_\_ Have you noticed any loose teeth or change in your bite?

\_\_\_ Does food tend to get caught between your teeth?

Where? \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Have you ever experienced:**

Problems of prolonged bleeding either from a cut, or a dental procedure such as cleaning? \_\_\_\_\_ Yes No \_\_\_\_\_

Have you ever been involved in an accident or injury (includes: sports injury, serious slips or falls, ski accidents, etc)

\_\_\_\_\_

When? \_\_\_\_\_

What happened? \_\_\_\_\_

Did the Symptoms start after this accident?

Explain: \_\_\_\_\_

\_\_\_\_\_

Is the Symptom(s) due to an illness, injury, or work related accident? \_\_\_\_\_ Yes No \_\_\_\_\_

Place of the accident or injury? \_\_\_\_\_

Date and Time of accident? \_\_\_\_\_

Explain: \_\_\_\_\_

**Have you had:**

Recent X-rays? Full mouth series \_\_\_\_\_ Jaw Joints \_\_\_\_\_ MRI \_\_\_\_\_ CT Scans When? \_\_\_\_\_

Date of last eye examination? \_\_\_\_\_