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Dental History

Patient name ______________________________ Date______________________

Date of last dental visit ______ Last dental cleaning _______ Last Full Mouth Xrays __________

Previous Dentist Name _________________________ Telephone____________________

Address ____

How often do you have a dental exam? __________________

How often do you brush? __________ Floss? __________

Do you active dental problems now? ___Yes No___

Gum disease? ○ Yes ○ No   Bleeding gums? ○ Yes ○ No

Decay? ○ Yes ○ No   Broken teeth? ○ Yes ○ No

Do you trouble with bad breath? ○ Yes ○ No

Do you have any loose teeth? ○ Yes ○ No   Where?____________________

Do you get food caught between teeth often? ○ Yes ○ No   Where? ______________

Have you ever had:

Orthodontic treatment ○ Yes ○ No   Your teeth ground or bite adjusted ○ Yes ○ No

Periodontal treatment ○ Yes ○ No   General anaesthesia ○ Yes ○ No

Endodontic treatment ○ Yes ○ No   A broken jaw ○ Yes ○ No

Injections in your TM Joint ○ Yes ○ No   A bite appliance ○ Yes ○ No

Oral surgery or teeth removed ○ Yes ○ No

When and by whom ____

Do you:

Clench or grind your teeth ○ AM ○ PM   Chew gum ○ Yes ○ No

Experience headaches ○ Yes ○ No   Bite pencils/pens ○ Yes ○ No

Teeth hit in front first ○ Yes ○ No   Cheek biting ○ Yes ○ No

Nail biting ○ Yes ○ No   Experience cold sores ○ Yes ○ No

Other habits: ____

Are your teeth sensitive to:

Hot: ○ Yes ○ No   Cold: ○ Yes ○ No

Sweet: ○ Yes ○ No   Soreness biting: ○ Yes ○ No

Have you experienced prolonged bleeding? ○ Yes ○ No

When, describe ____

Have you had an accident, experienced trauma? ○ Yes ○ No

Describe incident, date & symptoms... ______________________________

____

Do you snore or have sleep apnea (stop breathing)? ○ Yes ○ No

Do you have cosmetic concerns/requests? ○ Yes ○ No

Describe____

____

Email
info@evergreendentistry.ca