

## DENTAL HISTORY

<b>Name</b>	<b>Medical Alert</b>
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*Welcome! So that we may provide you with the best possible care, please complete this dental history form.  
All information is completely confidential.*

**What is the reason for your visit today?**

**Date of last dental visit?**

What was done at your last dental visit?

**Last dental cleaning?**

Previous dentist's name?

Address and telephone

How often do you have dental exam?

How often do you brush your teeth? Floss?

What are other dental aids you use? (Toothpick, Interplak, etc.)

Do you have any dental problem now? Yes / No If yes, please describe:

**Are any of your teeth sensitive to:**

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or chewing	Yes	No
Mouth odor or bad taste?	Yes	No
Do you frequently get cold sores, blisters, or any other oral lesions?	Yes	No
<b>Do your gums bleed or hurt?</b>	Yes	No

**Have you ever had:**

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Gum treatment?	Yes	No
Your teeth ground or bite adjusted?	Yes	No
A night guard?	Yes	No
Serious injury to the mouth or head?	Yes	No
If so, please describe		

Have your parents experienced gum disease? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to caught in between your teeth?  
If yes, where? Yes No

**Do you**

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke/chew tobacco? Yes No

**Have you experienced?**

Clicking or popping of the jaw? Yes No

Pain?(joint, ear, side of face) Yes No

Difficulty of opening or closing of the mouth? Yes No

Headaches, neck aches or shoulder aches Yes No

**Are you satisfied with your teeth's appearance?**

Would you like to keep all of you teeth? Yes No

Do you feel nervous about dental treatment? If so please describe Yes No

Have you ever had an upsetting dental experience? If yes, please describe Yes No

Is there anything else about having dental treatment that you would like us to know? If yes, please describe