Dental History

			Comments
1. What is the reason for your visit?_____			
2. Are you having any specific problems with your teeth, gums or mouth?	Yes	No	
3. Are your teeth sensitive to hot, cold or sweets?	Yes	No	
4. Do you have any fever blisters, mouth ulcers or sores on your lips or mouth?	Yes	No	
5. Do you often have chapped lips, cracked or raw places in corners of your mouth?	Yes	No	
6. Do your gums bleed after brushing or are they often sore or tender?	Yes	No	
7. Do you have difficulty swallowing, chewing or do you frequently chew on one side only?	Yes	No	
8. Do you frequently wedge food between your teeth?	Yes	No	
9. Have you worn braces for straightening your teeth?	Yes	No	
10. In general, do dental treatments cause you much concern or worry?	Yes	No	
11. Do you chew or smoke tobacco in any form?	Yes	No	
12. Are you dissatisfied with the appearance of your teeth?	Yes	No	
13. What kind of toothbrush to you use? ☐ hard..... ☐ medium ☐ soft			
14. How many times a day do you brush your teeth?_____			
15. When do you floss your teeth?_____			
16. When was your last dental checkup?_____			
Dental x-rays?_____ Dental cleaning?_____			
17. Do you clench or grind your teeth?.....	Yes	No	
18. Do you notice popping, clicking or soreness in the jaws or in front of your ears: ..... Which side? _____	Yes	No	
19. Do you have frequent headaches, earaches, or stiffness or soreness in your neck?.....	Yes	No	

Update Information (Office Use Only)

Date	*Comment*	*Initials*	*Date*	*Comment*	*Initials*

DO YOU HAVE ANY QUESTIONS? PLEASE ASK US!

Patient's (if under 18 Parent's/Guardian's) signature _____ Date _____

Dentist's signature _____ Date _____

Witness/Interpreter's signature _____ Date _____