Dental Health History

Patient Name_____

Date_____

What is the reason for today's visit?_____
Are you currently having dental pain or discomfort? If yes, where?_____
When was your last dental exam?_____
What was your last dental cleaning/therapy? _____
When was the last time you had dental x-rays taken?_____
How often do you brush your teeth?_____ Floss?_____
Do your gums bleed when you brush or floss?.....YES NO
Are your teeth sensitive to:

- cold ……...YES NO
- hot…….....YES NO
- sweets…….....YES NO
- chewing or pressure?.....YES NO

Do you have dry mouth?.....YES NO
Do you take fluoride supplements?.....YES NO
Have you ever had periodontal therapy, i.e. deep cleaning or grafting?.....YES NO
Have you worn braces or had other orthodontic treatment?.....YES NO
Have you had problems with previous dental treatment?.....YES NO

- Please explain_____

Are you apprehensive about dental treatment?.....YES NO
Do you gag easily?.....YES NO
Do you have TMJ pain?.....YES NO
Does your jaw lock open or closed? ……..…….YES NO
Does your jaw click or pop?.....YES NO
Is your oral opening limited due to TMJ pain?.....YES NO
Do you clench or grind your teeth during the daytime?.....YES NO
Do you clench or grind your teeth at night?……..……...YES NO
Do you have headaches or ear, neck or facial pain upon waking in the morning?.....YES NO
Have you ever had an injury to the head, jaw, mouth or face?.....YES NO

- Please explain_____

Do you habitually chew gum?.....YES NO
Do you currently wear a nightguard?.....YES NO
Do you get sores in or around your mouth?.....YES NO
Is your home water supply fluoridated?.....YES NO
Do you drink bottled water?.....YES NO

- How often: occasionally, daily, weekly?

Do you wear complete dentures or partial dentures?.....YES NO
Do you participate in sports?.....YES NO
Which sports?_____
Do you have a specific goal for your dental treatment? Please explain_____