# DENTAL HISTORY

Patient's Name _____
Last First Initial DOB

**Dental History** – Please describe and/or circle the appropriate answer

| | | | |
|---|---|---|---|
| 1. | Purpose of initial visit? | | |
| 2. | Are you aware of any problems? | | |
| 3. | How long since your last dental visit? | | |
| 4. | What was done at that time? | | |
| 5. | Previous dentist's name: | | |
| 6. | When was the last time your teeth were cleaned? | | |
| 7. | Have you made regular dental visits?<br>How Often? | YES | NO |
| 8. | Were dental x-rays taken? | YES | NO |
| 9. | Have you lost any teeth or have any teeth been removed?<br>Why? | YES | NO |
| 10. | Have these missing teeth been replaced? | YES | NO |
| 11. | How have the teeth been replaced?<br>☐ Fixed bridge Year placed:<br>☐ Removable bridge Year placed:<br>☐ Denture Year placed:<br>☐ Implant Year placed: | | |
| 12. | Are you unhappy with the replacement?<br>If yes, explain: | YES | NO |
| 13. | Would you like to know about permanent replacements? | YES | NO |
| 14. | Have you ever had any problems or complications with previous dental treatment? If yes, explain: | YES | NO |
| 15. | Do you clench or grind your teeth? | YES | NO |
| 16. | Does your jaw click or pop? | YES | NO |
| 17. | Have you experienced any pain or soreness in the muscles of your face, neck, ears, or jaw? | YES | NO |
| 18. | Do you have frequent headaches, neck aches or shoulder aches? | YES | NO |
| 19. | Does food get caught in your teeth? | YES | NO |
| 20. | Are any of your teeth sensitive to: hot cold sweets pressure | YES | NO |
| 21. | Do your gums bleed or hurt? When: | YES | NO |
| 22. | How often do you brush your teeth? When? | | |
| 23. | Do you use dental floss? How often? | YES | NO |
| 24. | Are any of your teeth loose, tipped, shifted or chipped? | YES | NO |
| 25. | Are you unhappy with the appearance of your teeth? | YES | NO |
| 26. | How do you feel about your teeth in general? | | |
| 27. | Do you feel your breath is offensive at times? | YES | NO |
| 28. | Have you ever had gum treatment or surgery? | YES | NO |
| 29. | Have you had any orthodontic work? | YES | NO |
| 30. | Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? | | |
| 31. | Do you have any questions or concerns? | YES | NO |

## COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____