Dental History

Name: ____ Date: _____________________

YES NO Are you presently in any dental pain? Explain: ____
YES NO Do you have any pain due to hot, cold, or sweets? Where? ________________________________
YES NO Does food catch between your teeth? Where? ____
YES NO Do your gums bleed while brushing, flossing, chewing, or at any other time? When? ______
YES NO Have you had orthodontics? If so, when were the braces removed? _______________________
YES NO Do you have any missing teeth? _________________
YES NO Do you avoid brushing any part of your mouth? Where? __________________________________
Do you brush lightly or vigorously? ____
How often do you brush? ____
Floss? ____
YES NO Do you have an unpleasant odor or taste in your mouth?
YES NO Do you clench or grind your teeth; Has anyone made you aware you clench or grind?
YES NO Do you visit the dentist regularly?
Date of last dental visit? ____
YES NO Do you have headaches, neck aches, chronic neck or shoulder pain? If so, where? ________
YES NO Do you have any growths or swellings in your mouth? Where? ___________________________
YES NO Do you know that decay and gum disease can occur without your being aware of it?

Patient Signature: ____ Date: _______________________

Notes: ____
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Doctor Signature: ____ Date: ___________________________