Dental History Form

YES / NO

Y N Is it important for you to keep your teeth?
Y N Are you satisfied with the appearance of your teeth?
Y N Does food frequently get caught between teeth?
Y N Do your gums often bleed while brushing?
Y N Have you noticed loosening of your teeth?
Y N Have you injured your head, neck, or jaw?
Y N Do you have difficulty eating or swallowing?
Y N Does your mouth feel dry?

Problems of the jaw- have you noticed…

Y N Clicking of the jaw?
Y N Pain (joint, ear, side of face)?
Y N Difficulty opening or closing?
Y N Difficulty chewing?

Oral habits- Do you…

Y N Clench or grind your teeth?
Y N Bite your lips or cheek frequently?
Y N Smoke or use chewing tobacco? Which type _____

Have you had…

Y N Orthodontic treatment (braces)?
Y N Oral Surgery?
Y N Periodontal/gum treatment (deep cleaning or scaling)?
Y N A bite plane/guard or other appliance?

Do you currently have…

Y N Dental pain?
Y N Sores or swellings in your mouth?
Y N A partial/full denture or dental implants?
Y N Any unfinished dental work?
Y N Have you had any difficulty with dental treatment?

How often do you brush your teeth? _____

What type of toothbrush do you use? Manual / Electric

Do you clean between your teeth? Yes / No

Approximately how long ago were you last seen by a dentist?_____

Reason for today's visit? _____

_____