

# DENTAL HISTORY

PATIENT NAME _____	DATE _____
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*Welcome! So that we may provide you with the best possible care, please take a moment to fill out both sides of this form as completely as you can.*

**Please check Yes or No and/or complete in detail.**

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Reason you made this appointment _____   |                          |                          |
| 2. When did you last visit the dentist? _____   |                          |                          |
| 3. How often did you visit the dentist before then? _____   |                          |                          |
| 4. Are you presently in any dental pain? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please describe _____   |                          |                          |
| 5. Have you ever had an unpleasant experience at the dentist? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please describe _____   |                          |                          |
| 6. Have you ever had:   |                          |                          |
| Orthodontic treatment? If yes, give year _____ .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Periodontal Treatment? If yes, give year _____ .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Oral Surgery? If yes, give year _____ .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Your bite adjusted? If yes, give year _____ .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Root canal treatment? If yes, give year _____ .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Cosmetic dentistry? If yes, give year _____ .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental implants? If yes, give year _____ .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever lost any teeth? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, from what cause and when _____  |                          |                          |
| 8. Have you ever had an injury to the head, jaws or mouth? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, describe and when _____   |                          |                          |
| 9. Are you satisfied with your teeth and their appearance? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| What would you like to change, ideally? _____   |                          |                          |
| 10. Does dental treatment make you nervous? If yes, <input type="checkbox"/> Moderately or <input type="checkbox"/> Extremely ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you want to learn how to control dental disease and retain your natural teeth? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Are you deeply concerned about the finances required to return your mouth to excellent dental health? ..                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever neglected, cancelled, or not shown up for dental appointments in the past? .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain reasons _____   |                          |                          |

**ORAL HEALTH**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. How often do you brush your teeth? _____   |                          |                          |
| 2. Do you floss your teeth? If yes, how often? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you use a fluoride or other rinse? If yes, how often? .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do your gums bleed when you brush? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use any other dental aids? (toothpick, electric toothbrush, etc.) If yes, what? ..    | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does your food tend to become caught between your teeth? If yes, where? ..                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you hold foreign objects in your teeth (such as pencils, pipes, pins, fingernails)? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had professional instructions in oral hygiene? .....                           | <input type="checkbox"/> | <input type="checkbox"/> |

**Have you ever had any of the following? (Check boxes that apply)**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Sore gums                         | <input type="checkbox"/> Swelling/lumps in mouth        | <input type="checkbox"/> Soreness in facial muscles                | <input type="checkbox"/> Teeth sensitive to hot    |
| <input type="checkbox"/> Unpleasant taste, odor/bad breath | <input type="checkbox"/> Clicking/popping jaw joint     | <input type="checkbox"/> Headaches, neckaches and/or shoulder pain | <input type="checkbox"/> Teeth sensitive to cold   |
| <input type="checkbox"/> Burning tongue, lips              | <input type="checkbox"/> Difficulty opening/closing jaw | <input type="checkbox"/> Change in bite                            | <input type="checkbox"/> Teeth sensitive to sweets |
| <input type="checkbox"/> Frequent blisters, cold sores     | <input type="checkbox"/> Clenching/grinding teeth       | <input type="checkbox"/> Loose teeth                               | <input type="checkbox"/> Biting lips or cheeks     |
| <input type="checkbox"/> Dry mouth                         |   |  | <input type="checkbox"/> Shifting in teeth         |
|  |   |  | <input type="checkbox"/> Snoring                   |

# DENTAL HISTORY

Please check one box below per section.

- |   |   |
|---|---|
| <p>I. <input type="checkbox"/> think the appearance of my mouth is excellent.<br/> <input type="checkbox"/> think the appearance of my mouth is adequate.<br/> <input type="checkbox"/> wish I could change the appearance of my mouth.</p> <p>II. <input type="checkbox"/> want to save my teeth at all costs.<br/> <input type="checkbox"/> prefer to keep my teeth if cost &amp; time are reasonable.<br/> <input type="checkbox"/> expect to someday loose my teeth and have dentures.</p> <p>III. <input type="checkbox"/> have set goals to achieve optimum oral health with a previous dentist.<br/> <input type="checkbox"/> want to set goals concerning my dental health.<br/> <input type="checkbox"/> usually only go to the dentist for problems or emergencies.</p> | <p>IV. <input type="checkbox"/> desire EXCELLENT oral health.<br/> <input type="checkbox"/> desire AVERAGE OR GOOD oral health.<br/> <input type="checkbox"/> desire crisis care only.</p> <p>V. <input type="checkbox"/> have always done the best that was recommended for my dental health.<br/> <input type="checkbox"/> have not done what dentists recommended for me.<br/> <input type="checkbox"/> rarely go, and don't care much about having any dental work completed.</p> |
|---|---|

If you are wearing a PARTIAL or COMPLETE denture please complete boxed in area below.

	YES	NO
1. For what reason did you loose your teeth _____		
2. When did you receive your first denture? _____		
3. How many complete or partial dentures have you had? Upper _____ Lower _____		
4. How long have you worn your present denture? Upper _____ Lower _____		
5. Has it been relined? If yes, how long ago _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Who made your last denture? _____		
7. Do you have a present denture problem? _____ If yes, please describe _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you satisfied with their appearance? _____ If no, why _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you satisfied with the comfort? _____ If no, why _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you satisfied with the chewing ability? _____ If no, why _____	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you wear your dentures 24 hours a day? _____	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you bite your tongue or cheeks with your dentures? _____	<input type="checkbox"/>	<input type="checkbox"/>
13. Do your dentures click during speech? _____	<input type="checkbox"/>	<input type="checkbox"/>
14. Is your speech influenced by your dentures? _____ If yes, describe _____	<input type="checkbox"/>	<input type="checkbox"/>
15. What do you expect from your new dentures (partial or complete)? _____ _____ _____		
16. Are you interested in hearing about dental implants? _____	<input type="checkbox"/>	<input type="checkbox"/>

Please add any comments that you feel will assist this dental team in our concern for your treatment.  
 \_\_\_\_\_  
 \_\_\_\_\_

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my medical dental health, I will inform the dentist at my next appointment.

Signed: \_\_\_\_\_  
*(patient, parent if minor, or guardian)*

Date: \_\_\_\_\_

Signed: \_\_\_\_\_  
*(Dentist)*

Date: \_\_\_\_\_