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DENTAL HISTORY

Name _____ Date _____

1. What is your immediate dental concern? _____
2. Have you ever had orthodontic treatment? _____ When? _____
3. Do you have any growths or swelling in your mouth? _____
4. How long have they existed? _____
5. Do you have difficulty in swallowing? _____
6. Do your gums bleed when brushing your teeth? _____
7. Do you avoid brushing any part of your mouth? _____
8. Why? _____
9. Have you ever been told you have gum disease? _____ When? _____
10. Do you smoke? _____ How much? _____
11. Is any part of your mouth sensitive to temperature or pressure? _____
12. Does food catch between your teeth? _____
13. Do you ever awaken with an awareness of your teeth or jaws? _____
14. Are you aware of clenching your teeth during the daytime? _____

DENTAL HISTORY

15. How often? _____

16. Have you ever been told our grind your teeth during sleep? _____

17. Are you aware of clicking or popping in the jaw? _____ How often? _____

18. Do you have tension headaches? _____ How often? _____

19. Do you have an unpleasant taste or odor in your mouth? _____

20. Do you have any medical conditions the Doctor should be aware of? _____

21. What would you like to improve about the appearance of your teeth or smile if your could? _____

_____

22. Would you be interested in whiter teeth? _____

23. What did you like most about your last dentist? _____

24. What did you dislike most? _____

25. “I feel the condition of my teeth are”: _____Excellent _____Good _____Fair _____Poor