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DENTAL HISTORY

PATIENT NAME: _____ DATE:_____

1. REASON FOR VISIT:_____
2. DATE OF LAST DENTAL TREATMENT:_____
3. ARE YOU HAVING PAIN AT THIS TIME? YES NO
4. HAVE YOU EVER HAD:
   - ORTHODONTIC TREATMENT? YES NO
   - ORAL SURGERY? YES NO
   - PERIODONTAL TREATMENT? YES NO
   - YOUR TEETH GROUND OR BITE ADJUSTED? YES NO
   - A BITE PLATE, DENTURES OR OTHER APPLIANCE? YES NO
5. HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH? YES NO
6. DO YOU SUFFER FROM PAIN AND/OR SWELLING OF YOUR GUMS? YES NO
7. DO YOUR GUMS OFTEN BLEED WHEN YOU BRUSH YOUR TEETH? YES NO
8. PROBLEMS OF THE JAW. HAVE YOU EVER EXPERIENCED:
   - CLICKING OF THE JAW? YES NO
   - PAIN (JOINT, EAR, SIDE OF FACE)? YES NO
   - DIFFICULTY IN OPENING AND CLOSING? YES NO
   - DIFFICULTY IN SPEAKING? CHEWING? SWALLOWING? YES NO
   - CHANGES IN THE WAY YOU BITE? YES NO
9. HABITS—DO YOU:
   - CLENCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? YES NO
   - BITE YOUR LIPS OR CHEECKS REGULARLY? YES NO
   - HOLD FOREIGN OBJECTS WITH YOUR TEETH? (SUCH AS: PENCILS, PIPE, PINS, NAILS, BITE FINGERNAILS?) YES NO
10. DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT? YES NO
11. BREATHING ISSUES:
    - DO YOU HAVE BREATHING PROBLEMS? YES NO
    - DO YOU HAVE INTERRUPTED SLEEP PATTERNS? YES NO
    - DO YOU SNORE DURING SLEEP? YES NO
12. ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? YES NO

    IF NO, PLEASE EXPLAIN WHAT YOU WOULD LIKE TO CHANGE ABOUT THE APPEARANCE OF YOUR TEETH:

    _____

    _____

    _____