

# DENTAL HISTORY

Patient Name \_\_\_\_\_

1. Last visit to dentist: \_\_\_\_\_ Reason: \_\_\_\_\_

2. Please check off what was done at that visit:

Emergency  Crown  Bridge  X-rays  Extraction  Fillings  Bonding  Root Canal  Gum Treatment  Cleaning

3. Reason for today's visit: \_\_\_\_\_

4. Any discomfort at this time?  Yes  No

Aware of any dental problems? \_\_\_\_\_

5. Do you go for regular exams and teeth cleaning?  Yes  No

6. Have you lost any teeth?  Yes  No  How many? \_\_\_\_\_

7. Have they been replaced?  Yes  No

8. Are you pleased with your smile?  Yes  No

9. What goals do you have in treatment of your mouth?

Improve Appearance  Eliminate Discomfort  Replace Missing Teeth  Stop Gums from Bleeding  Other \_\_\_\_\_

10. How often do you brush your teeth? \_\_\_\_\_

What type of bristle do you use?  Hard Bristle  Soft Bristle  Electric

11. How often do you floss your teeth? \_\_\_\_\_

Do you use a toothpick or stimudent?  Yes  No

Do you use a water irrigating device?  Yes  No

Other home care methods: \_\_\_\_\_

12. Are you aware of any swellings or lumps in your mouth?  Yes  No

13. Do you consistently hear clicking, snapping or popping noises when you chew?  Yes. If so, which side? \_\_\_\_\_  No

14. Do you have a history of your gums bleeding?  Yes  No

15. Would you like to retain your healthy teeth as long as possible?  Yes  No

16. Are you self-conscious about the appearance of your teeth?  Yes  No

17. In the past, have you been pleased with the dental treatment you have received?  Yes  No

If not, why? \_\_\_\_\_