DENTAL HISTORY

DATE _____

☐ YES ☐ NO Do you have any specific problems?

☐ YES ☐ NO Do you have any unhealed injuries or inflamed areas in or around your mouth?

☐ YES ☐ NO Have you experienced any growths or sore spots in your mouth?

☐ YES ☐ NO Does any part of your mouth hurt when your teeth are clenched?

☐ YES ☐ NO Have you ever had Novocaine or other local anesthetics?

☐ YES ☐ NO Have you ever had allergic or other adverse reaction to Novocaine or other local anesthetic?

☐ YES ☐ NO Have you ever had difficulty with extractions in the past?

☐ YES ☐ NO Have you had prolonged bleeding following extraction or other procedures?

☐ YES ☐ NO Do your gums bleed?

☐ YES ☐ NO Have you ever been instructed in a proper method of brushing your teeth?

☐ YES ☐ NO Have you ever been instructed in the care of your gums?

☐ YES ☐ NO Do you smoke? If so, how much_____

☐ YES ☐ NO Do you frequently bite your cheeks or tongue?

☐ YES ☐ NO Are any of your teeth sensitive to biting, pressure, sweets, heat or cold?

If so, locate

☐ YES ☐ NO Do you have a bad taste in your mouth?

☐ YES ☐ NO Do you have a dry mouth?

☐ YES ☐ NO Do you have areas where food collects?

☐ YES ☐ NO Do you frequently have blisters or sores in or around your mouth?

How often do you brush your teeth? ☐ once daily ☐ twice daily ☐ three or more times daily

☐ YES ☐ NO Do you use dental floss?

If yes, how frequently?

What type of toothbrush do you use? ☐ hard ☐ medium ☐ soft

How would you rate your oral hygiene? ☐ Excellent ☐ Good

☐ Fair ☐ Poor

☐ YES ☐ NO Do you have difficulty in opening your mouth?

☐ YES ☐ NO Do you hear noises from your jaw joints?

☐ YES ☐ NO Do you have frequent headaches?

☐ YES ☐ NO Does your jaw get "stuck" or "locked" or does it ever "go out"?

☐ YES ☐ NO Do you have pain in or about your ears or cheeks?

☐ YES ☐ NO Does your bite feel uncomfortable or unusual?

☐ YES ☐ NO Have you had a recent injury to your head or neck? Describe

☐ YES ☐ NO Do you have arthritis?

☐ YES ☐ NO Do you have any muscle or joint problems?

☐ YES ☐ NO Have you ever been treated for temporomandibular joint (TMJ) disorders?

☐ YES ☐ NO Do you habitually clench your teeth?

☐ YES ☐ NO Do you habitually grind your teeth at night?

☐ YES ☐ NO Are you conscious of your bite?

When were your last full mouth x-rays taken

Where

When was your last dental treatment?

☐ YES ☐ NO Do you feel as if you have been receiving adequate dental care?

Is there anything else that you feel your dentist should know?

PATIENT'S NAME

DENTAL HISTORY **[ ] MEDICAL ALERT** _____