Dental History

Your Name ______________________________ Date ______________

When was your last dental visit and what treatment did you have? ________________________
Can you recall having an unpleasant dental experience (please explain)?

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Check all of the following that are true:

Have you worn braces? _____
Have you had a negative reaction to dental anesthesia? _____
Do you need to pre-medicate with antibiotics before dental treatment? _____
Are your teeth sensitive to hot, cold, sweets or percussion? _____
Have you experienced jaw pain, clicking, difficulty opening, closing or chewing? _____
Do you clench or grind your teeth? _____
Do you have frequent headaches? _____
Do you trap food in your teeth? _____
Do your gums ever feel tender or swollen? _____
Do your gums bleed when brushing? _____
Do you have any teeth that feel loose? _____
Have you ever been treated for periodontal disease? _____
Do you use dental floss? _____
Have you had any previous injuries to your face or jaws? _____
Do you lose or break fillings? _____
Do you seem to strike some teeth before others when closing? _____
Have you ever had your bite adjusted? _____
Can you chew comfortably on both sides of your mouth? _____
Have you had a complete dental exam, with full x-rays, in the past 3 years? _____
Have you had your teeth cleaned regularly? _____
Do you have all or most of your natural teeth? _____
If you've had teeth removed, have they been replaced? _____
Do you consider yourself a nervous dental patient? _____

Which of the following is most important to you?

Being relieved of dental pain _____

Maintaining overall oral health _____

Improving the appearance of your smile _____