

# PATIENT DENTAL HISTORY

Patient's name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Reason for this visit \_\_\_\_\_

Last dental visit (date) \_\_\_\_\_ Treatment provided at that time \_\_\_\_\_

Frequency of dental visits \_\_\_\_\_ Previous dentist (name and location) \_\_\_\_\_

Have you had a complete series of dental films/x-rays taken? \_\_\_\_\_ Where? \_\_\_\_\_

When? \_\_\_\_\_ Can we request these be sent to this office? \_\_\_\_\_

## Please indicate Yes (Y) or No (N) to the following:

Do your gums bleed while brushing or flossing? \_\_\_\_\_ Do you bite your lips/cheeks frequently? \_\_\_\_\_

Are your teeth sensitive to hot or cold? \_\_\_\_\_ Have you noticed any loosening of your teeth? \_\_\_\_\_

Are your teeth sensitive to sweets or sour? \_\_\_\_\_ Does food get caught between your teeth? \_\_\_\_\_

Do you feel pain in any of your teeth? \_\_\_\_\_ Have you had periodontal (gum) treatment? \_\_\_\_\_

Do you have any sores or lumps in or near your mouth? \_\_\_\_\_ Have you received oral hygiene instruction for the care of your teeth and gums? \_\_\_\_\_

Have you ever had any head, neck or jaw injuries? \_\_\_\_\_ Have you had difficult extractions before? \_\_\_\_\_

Have you ever experienced any of the following problems in your jaw? \_\_\_\_\_ Have you had prolonged bleeding following extractions before? \_\_\_\_\_

Clicking \_\_\_\_\_ If yes, date of placement \_\_\_\_\_

Pain (joint, ear or side of face) \_\_\_\_\_ Do you have dental implants? \_\_\_\_\_

Difficulty in opening/closing \_\_\_\_\_ If yes, date of placement \_\_\_\_\_

Difficulty in chewing \_\_\_\_\_ Have you had orthodontic treatment? \_\_\_\_\_

Do you have frequent headaches? \_\_\_\_\_ If yes, date of completing \_\_\_\_\_

Do you clench or grind your teeth? \_\_\_\_\_ Have you had treatment from a dental specialist? \_\_\_\_\_

If yes, what type? \_\_\_\_\_

Additional comments or concerns? \_\_\_\_\_

Dentist's comments \_\_\_\_\_

\_\_\_\_\_  
Patient's/Parent's/Guardian's signature      Date      Dentist's signature      Date