Comprehensive Family and Cosmetic Dentistry

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NAME:_____ DATE:_____

DENTAL HISTORY

1.	Reason for visit?_____		
2.	When was your last dental visit?_____		
3.	How often do you brush your teeth?_____		
4.	How often do you floss your teeth?_____		
5.	Do your gums bleed while brushing and/or flossing?	☐Y	☐N
6.	Are your teeth sensitive to brushing and flossing?	☐Y	☐N
7.	Are your teeth sensitive to cold, hot, or sweet liquids or foods?	☐Y	☐N
8.	Does chewing result in pain to any of your teeth?	☐Y	☐N
9.	Have you noticed any loosening of your teeth?	☐Y	☐N
10.	Does food tend to become trapped between any of your teeth?	☐Y	☐N
11.	Do you have any sores or lumps in or near your mouth?	☐Y	☐N
12.	Have you had any head, neck or jaw injuries?	☐Y	☐N
13.	Do you have frequent headaches?	☐Y	☐N
14.	Do you clench or grind your teeth while awake or asleep?	☐Y	☐N
15.	Have you ever experienced any of the following?		
	a) clicking or popping of jaw joint(s)	☐Y	☐N
	b) jaw joint pain	☐Y	☐N
	c) difficulty in opening, closing or chewing?	☐Y	☐N
16.	Have you ever had:		
	a) orthodontic treatment (braces)?	☐Y	☐N
	b) periodontal treatment (gums)?	☐Y	☐N
	c) oral surgery treatment?	☐Y	☐N
	d) your bite adjusted?	☐Y	☐N
	e) worn a dental nightguard, splint or other appliance?	☐Y	☐N

17. Are you happy with the overall appearance of your teeth? If no, please elaborate:_____
_____

18. Are there any special concerns you have in regard to your dental treatment? If so, please elaborate:_____
_____