

# Dental History

What prompted you to seek dental care at this time?			
<input type="checkbox"/> Routine care--no problems <input type="checkbox"/> Cosmetic consult <input type="checkbox"/> I have tooth pain <input type="checkbox"/> I have gum problems <input type="checkbox"/> Other--(specify)			
How long since your last thorough dental exam?			
<input type="checkbox"/> Less than 6 months <input type="checkbox"/> 6-12 Months <input type="checkbox"/> 1-2 Years <input type="checkbox"/> > 2 years <input type="checkbox"/> Never/I don't			
Have you recently (within the past year or two) had any of the following?			
Dental Cleaning	Bite wing x-rays	Full Mouth x-rays	Panoramic x-ray
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
How often do you go to the dentist for routine cleanings and examinations?			
<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Every few years <input type="checkbox"/> Yearly <input type="checkbox"/> Every 6 months <input type="checkbox"/> More than twice per year			
How often do you brush your teeth?			
<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> 1-2 times weekly <input type="checkbox"/> Daily <input type="checkbox"/> More than once daily			
How often do you floss your teeth?			
<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> 1-2 times weekly <input type="checkbox"/> Daily <input type="checkbox"/> More than once daily			
	Check One:	Explain "Yes" answers	
Have you had any discomfort from your teeth or gums lately?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are your teeth sensitive to hot or cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Would you like to change anything about your smile?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do your teeth need to be whiter?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do your gums bleed when you brush or floss?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have your teeth shifted in position or alignment in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does food often get stuck in between certain teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does your jaw pop when you open or close your mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you habitually grind or clench your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you now wear or expect to wear dentures someday?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have missing teeth you want replaced?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you habitually chew on anything?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you frequently snack on sweets?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does going to the dentist scare you?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever had a particularly bad experience at the dentist?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Check the dental procedures you have experienced:			
<input type="checkbox"/> Cleanings	<input type="checkbox"/> Sealants	<input type="checkbox"/> Root canals	<input type="checkbox"/> Extractions
<input type="checkbox"/> Fillings	<input type="checkbox"/> Bleaching	<input type="checkbox"/> Deep Scaling	<input type="checkbox"/> Other Oral Surgery
<input type="checkbox"/> Braces	<input type="checkbox"/> Crowns	<input type="checkbox"/> Periodontal Surgery	<input type="checkbox"/> TMJ Treatment
<input type="checkbox"/> Bonding/Veneers	<input type="checkbox"/> Bridges	<input type="checkbox"/> Bite Adjustment	<input type="checkbox"/> Dental Implants
Is there anything else about having dental treatment that you would like us to know?			

Name: \_\_\_\_\_