DENTAL HISTORY

Patient Name _____

What is your reason for your visit today?_____

Date of last exam_____last cleaning_____last xrays_____

Previous dentists name?_____ phone number_____

How often do you brush your teeth?_____

How often do you floss?_____

Is the texture of your toothbrush HARD MEDIUM SOFT ?

Are you having pain or discomfort at this time?	yes	no
Do you feel nervous about dental treatment?	yes	no
Have you ever had a bad experience in the dental office?	yes	no
Have you ever had periodontal treatment (gums)?	yes	no
Have you ever had orthodontic treatment (braces)?	yes	no
Are your teeth sensitive to hot, cold, sweets or chewing?	yes	no
Do you clinch or grind your teeth?	yes	no
Do you have popping or clicking of the jaw?	yes	no
Do your gums bleed or hurt?	yes	no
Have you noticed any loose teeth or change in your bite?	yes	no
Does food become caught in between your teeth?	yes	no

If yes, where?_____

Have you ever wore a mouth / nite guard?	yes	no
Have you ever had trauma to the head or mouth?	yes	no

If so please explain?_____

Are you happy with the appearence of your smile?

MEDICAL HISTORY

Medical Doctors name_____Phone_____

Have you been hospitalized during the past 2 years? yes no

Explain_____

Have you been under the care of a a medical doctor in the past 2 years? yes no

Explain_____

Have you taken any medicine or drugs in the past 2 years? yes no

Explain_____

Are you currently taking any medications, drugs or pills? yes no

Explain_____

Are you allergic to any medication or drugs? yes no

Explain_____

On the next page please check any of the following you have or have had in the past.