

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

# Dental History

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Do your gums bleed when you brush or floss? YES NO

Do you have earaches or neck pain? YES NO

Are your teeth sensitive to cold, hot, sweets or pressure? YES NO

Do you have any clicking, popping or discomfort in the jaw? YES NO

Do you brux or grind your teeth? YES NO

Is your mouth dry? YES NO

Do you have sores or ulcers in your mouth? YES NO

Have you had any periodontal (gum) treatment? YES NO

Do you wear dentures or partials? YES NO

Do you have any dental implants? YES NO

Have you ever had orthodontic (braces) treatment? YES NO

Do you participate in athletic activities? YES NO

Have you had any problems associated with previous dental treatment? YES NO

If yes, explain: \_\_\_\_\_

Have you ever had a serious injury to your head or mouth? YES NO

Are you currently experiencing dental pain or discomfort? YES NO

Is your home water supply fluoridated? YES NO

Do you drink bottled or filtered water? YES NO

If yes, how often? Circle one: DAILY/WEEKLY/OCCASIONALLY

Do you smoke or use any tobacco products? YES NO

If yes, how often: \_\_\_\_\_ how many years: \_\_\_\_\_

Have you ever taken medication or been treated for osteoporosis? YES NO

Type of medication: \_\_\_\_\_ Dates taken from \_\_\_\_\_ to \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Date of last dental exam: \_\_\_\_\_ Date of last xrays: \_\_\_\_\_