Patient Name:______________________________________ Today's Date:______________

Dental History

Question		
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:_____________________