

PATIENT DENTAL HISTORY

PATIENT NAME _____

PATIENT ACCOUNT NO. _____ MEDICAL ALERT _____

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain in any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you had any orthodontic work? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | | | 14. Have you ever had instruction on the correct method of brushing your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| a) Clicking? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever had instructions on the care of your gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Pain (joint, ear, side of face)? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| c) Difficulty in opening or closing? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| d) Difficulty in chewing? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

What is the reason for your visit today? _____

Date of last dental visit _____

What was done at your last dental visit? _____

Do you have any dental problems now? YES NO

If yes, please describe: _____

Are you satisfied with the appearance of your teeth? YES NO

What would you change about your smile? _____

Do you brush, floss or use any other dental aids? _____

Is there anything else about having dental treatment that you would like us to know? YES NO

If yes, please describe _____

Certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____
 PATIENT, PARENT OR GUARDIAN DATE _____