Dental History Questionnaire

Thank you in advance for your time and attention give to the questions below, as this will help greatly in providing you our best care.

When was your last dental exam? ____
What did you have done at that dental visit? ______________________________________
How often do you have dental exams? ____
What tools do you use to keep your mouth healthy?
Toothbrush ___ Electric/Sonic Toothbrush ____ Toothpick ____ Floss___ Flossing Aid _____________
Other ______________________
Are any of your teeth sensitive to ☐ hot ☐ cold ☐ pressure ☐ chewing ☐ other: ________________
Have you noticed any mouth odors or bad tastes? ……………………………………….... ☐ No ☐ Yes
Do you frequently get cold sores, blisters, or other oral lesions? ………………………….. ☐ No ☐ Yes
Do your gums ever bleed or hurt? ……………………………………………………… ☐ No ☐ Yes
Have your parents experienced gum disease or tooth lose? ……………………………….. ☐ No ☐ Yes
Have you noticed any loose teeth or change in your bite? ………………………………… ☐ No ☐ Yes
Does food tend to become caught in between your teeth? ☐ No ☐ Yes…..Where? _______________
Do you clench or grind your teeth while awake or asleep? ……………………………….. ☐ No ☐ Yes
Do you bite your lips or cheeks regularly? ……………………………………………… ☐ No ☐ Yes
Do you hold pens, pencils, nails, fingernails with your teeth? …………………………….. ☐ No ☐ Yes
Do you mouth breath while awake or asleep? ……………………………………..…. ☐ No ☐ Yes
Do you have tired jaws, especially in the morning? …………………………………….. ☐ No ☐ Yes
Do you smoke or chew tobacco? ………………………………………………………... ☐ No ☐ Yes
Have you ever had:

- Orthodontic Treatment? ……………………………………………………………… ☐ No ☐ Yes
- Oral Surgery? (Extractions) ………………………………………………………….. ☐ No ☐ Yes
- Periodontal Treatment? (Seen a gum specialist) ………………………………….. ☐ No ☐ Yes
- Your bite adjusted or teeth ground? …………………………………………………. ☐ No ☐ Yes
- A mouth guard or bite guard? ……………………………………………………….. ☐ No ☐ Yes
- Any serious injuries to mouth or head? …………………………………………… ☐ No ☐ Yes

Have you ever experienced:

- Clicking or popping of the jaw? ……………………………………………………… ☐ No ☐ Yes
- Difficulty opening or closing the mouth? …………………………………………….. ☐ No ☐ Yes
- Difficulty Chewing on either side of the mouth, or chewing sensitivity? …………. ☐ No ☐ Yes
- Headaches, neck aches, or shoulder aches? ………………………………………... ☐ No ☐ Yes

Would you like to keep all your teeth all your life? ……………………………........... ☐ No ☐ Yes
Are you satisfied with your teeth's appearance? ………………………………………… ☐ No ☐ Yes
If not, what would you like to change? ____
Do you feel nervous about having dental treatment? ☐ No ☐ Yes If yes, what is your biggest dental concern? ____
Describe any upsetting dental experience: ____
____
Is there anything else about having dental treatment you would like us to know? ______________
____(use back of this page if necessary)

Name ________________________ **Date** ________________