# Dental History

Reason for today's visit _____

Date of last dental care _____ Date of last dental x-ray _____

How often do you brush? _____ When do you floss? _____

Check if you have had any of the following:

___ Cold Sores of Fever Blisters
___ Sensitive or Painful Teeth
___ Bad Breath (Halitosis)
___ Dry Mouth (Xerostomia)
___ Bleed Gums
___ Gum Surgery
___ "Deep Cleaning"
___ Periodontal Treatment
___ Jaw Pain
___ Clicking/Popping Jaw
___ Grinding of Teeth (Bruxism)
___ Clenching of Teeth
___ Pain in or about your ears
___ Frequent Headaches
___ Migraines
___ Neck-aches
___ Braces/Orthodontic Treatment
___ Loose Fillings
___ Broken Teeth/Fillings
___ Pain upon chewing/biting
___ Sensitivity to sweets
___ Food packs between teeth
___ Dental Implants
___ Wisdom Teeth Extraction

Do you participate in athletic activities? _____

Do you snore? _____

Are you apprehensive or nervous about dental treatment? _____

Would you be interested in sedation or "sleep" dentistry? _____

Do you feel you have a healthy mouth? _____

Do you like your smile? _____

Would you like whiter teeth? _____

Would you like straighter teeth? _____

Do you avoid certain foods due to missing teeth or pain upon chewing? _____

If you have missing teeth, would you like them replaced? _____

If you have a denture, are you satisfied with it? _____

What did you like most about previous dental experiences? _____

Why did you leave your previous dentist? _____

Is there anything we can do to make your visits more comfortable? _____