

## Dental History Form

**YES/NO**

- Y N Is it important for you to keep your teeth?
- Y N Are you satisfied with the appearance of your teeth?
- Y N Does food frequently get caught between teeth?
- Y N Do your gums often bleed while brushing?
- Y N Have you noticed loosening of your teeth?
- Y N Have you injured your head, neck, or jaw?
- Y N Do you have difficulty eating or swallowing?
- Y N Does your mouth feel dry?

### Problems of the jaw- have you noticed...

- Y N Clicking of the jaw?
- Y N Pain (joint, ear, side of face)?
- Y N Difficulty opening or closing?
- Y N Difficulty chewing?

### Oral habits- Do you...

- Y N Clench or grind your teeth?
- Y N Bite your lips or cheek frequently?
- Y N Smoke or use chewing tobacco? Which type \_\_\_\_\_

### Have you had...

- Y N Orthodontic treatment (braces)?
- Y N Oral Surgery?
- Y N Periodontal/gum treatment (deep cleaning or scaling)?
- Y N A bite plane/guard or other appliance?

### Do you currently have...

- Y N Dental pain?
- Y N Sores or swellings in your mouth?
- Y N A partial/full denture or dental implants?
- Y N Have you had any difficulty with dental treatment?

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

What type of toothbrush do you use? Manual / Electric

How often do you clean between your teeth? \_\_\_\_\_

Approximately how long ago were you last seen by a dentist? \_\_\_\_\_

Reason for today's visit? \_\_\_\_\_

\_\_\_\_\_