Dental History

What is the reason for your visit to our office?_____

Date of last dental visit? _____ What was done at that visit?_____

Date of last dental cleaning?_____

How often do you brush your teeth?_____

How often do you floss your teeth?_____

What other dental aids do you use?(toothpick, etc)_____

Are you satisfied with your teeth's appearance?_____

Do you feel nervous about having dental treatment?_____

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

_____

Are you having any pain with your teeth?

- □ No
- □ Yes Describe:_____

Are your teeth sensitive to any of the following:

- □ Cold
- □ Hot
- □ Biting or chewing
- □ Sweets

Do you use any of the following:

- □ Mouthwash or rinse
- □ Toothpick or stimulator
- □ Fluoridated water
- □ Bottled or filtered water

Have you ever had:

- □ Orthodontic treatment
- □ Bite splint
- □ Periodontal Treatment
- □ Oral surgery
- □ Serious injury to mouth or head

Do you do any of the following:

- □ Grind or clench teeth
- □ Bite cheek
- □ Tongue thrust
- □ Mouth breather
- □ Bulimia /Anorexia
- □ Smoke cigars or cigarettes
- □ Smoke pipe
- □ Other:_____ Describe:_____
- □ Bite nails
- □ Use smokeless tobacco
- □ Drink alcoholic beverages (if yes, how many per day __)
- □ Drink soft drinks (if yes, how many per day __)
- □ Chew gum
- □ Candy
- □ Suck thumb/finger