Dental History

	Yes	No
1. Please state briefly the reason for your visit. _____		
2. Do you have discomfort in your mouth now?	☐	☐
3. How long since your last dental visit? _____		
4. Were X-rays taken of all teeth at that time?	☐	☐
5. Do your gums bleed, feel tender or irritated?	☐	☐
6. Are your teeth sensitive to hot/cold/sweets?	☐	☐
7. Does food wedge between certain teeth?	☐	☐
8. Are any teeth loose?	☐	☐
9. Do you grind, clench or grit your teeth?	☐	☐
10. Does your jaw ever click or cause pain opening or closing?	☐	☐
11. Have your front teeth separated creating spaces in them recently?	☐	☐
12. Have you ever had any teeth extracted?	☐	☐
If yes, have they been replaced to prevent shifting and tipping of remaining teeth and bite collapse?	☐	☐
13. Did you ever wear braces?	☐	☐
14. Have you ever worn any dental appliances?	☐	☐
15. Have you ever had a root canal?	☐	☐
16. Have you ever had gum treatments?	☐	☐
17. Do you wear dentures or plates?	☐	☐
If yes, are you satisfied with your present dentures?	☐	☐
18. Have you experienced any growths or sore spots in your mouth?	☐	☐
19. Do you have an unpleasant taste in your mouth?	☐	☐
20. Do you floss your teeth?	☐	☐

21. Type of tooth brush _____ hard or soft (circle one)

Updating _____

_____

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Dental History Summary