Dental Health History:

Patient name_____

Reason for this visit _____

When was your last dental visit _____what was done then _____

How often did you visit the dentist before then _____

Previous dentist (name and location) _____

How often do you brush your teeth _____ how often do you floss your teeth _____

Is your drinking water fluoridated _____Y _____ N

	yes	no		yes	no
Do your gums bleed while brushing or flossing……	□	□	do you bite your lips or cheeks…….	□	□
Are your teeth sensitive to hot or cold liquids/foods……..	□	□	have you noticed any loosening of your teeth……..	□	□
Are your teeth sensitive to sweet/sour liquids/foods…… ….	□	□	does your food tend to become caught between your teeth..	□	□
do you feel pain to any of your teeth….	□	□	have you ever had periodontal treatment (gums)……..	□	□
do you have any sores or lumps in or near your mouth…… .	□	□	ever worn a bite plate……	□	□
have you had any head, neck, or jaw injuries	□	□	have you ever had any difficult extractions in the past…….	□	□
have you experienced any of the following problems in your jaw?			have you ever had any prolonged bleeding following extractions…….	□	□
clicking……	□	□	do you wear dentures or partials…….	□	□
pain……	□	□	if yes, date of placement_____		
difficulty opening or closing	□	□	have you ever received oral hygiene instructions regarding the care of your teeth and gums……	□	□
difficulty in chewing……	□	□			
do you have frequent headaches……	□	□			
do you clench or grind your teeth……	□	□			

If you could change anything about your smile, what would you change?

Signature of patient or parent/guardian if minor *date*