



Patient Dental History

Name of previous dentist and location _____

Date of Last Exam _____ Were x-rays taken? Yes No

If there anything about your smile you would like to change or improve?..... Yes No

If yes, what would you like to change? _____

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

Do you use tobacco products? Yes No

If yes, what kind? _____ How Frequently and for how many years? _____

Are you diabetic? Yes No

Date of latest A1C score _____ How do you treat it? _____

Do your gums bleed while brushing or flossing? Yes No

Are your teeth sensitive to hot or cold liquids/foods? Yes No

Are your teeth sensitive to sweet or sour liquids/foods? Yes No

Do you feel pain to any of your teeth? Yes No

Do you have any sores or lumps in or near your mouth? Yes No

Have you had any head, neck or jaw injuries? Yes No

Have you ever experienced any of the following problems in your jaw:

Clicking Yes No

Pain (joint, ear, side of face)? Yes No

Difficulty in opening or closing? Yes No

Difficulty in chewing? Yes No

Do you have frequent headaches? Yes No

Do you clench or grind your teeth? Yes No

Do you bite your lips or cheeks frequently? Yes No

Have you ever had any difficult extractions in the past? Yes No

Have you ever had any prolonged bleeding following extractions? Yes No

Have you had any orthodontic treatment? Yes No

Have you had any periodontal (gum disease) treatment? Yes No

Do you wear dentures or partials? Yes No

If yes, date of placement _____

Have you ever received instructions regarding the care of your teeth and gums? Yes No