DENTAL HISTORY

Date:	Patient Name:	Birth Date:

Previous Dentist:	
Address:	Phone:
Date of Last Appointment:	Date of Last X-Ray:
Why did you leave your previous dentist?	

Please check (✓) if you have or have had problems with any of the following:			
☐ Yes ☐ No	Bad breath	☐ Yes ☐ No	Gums swollen or tender
☐ Yes ☐ No	Bleeding gums	☐ Yes ☐ No	Jaw pain or tiredness
☐ Yes ☐ No	Blisters on the lips or mouth	☐ Yes ☐ No	Lip or cheek biting
☐ Yes ☐ No	Burning sensation on tongue	☐ Yes ☐ No	Loose teeth or broken fillings
☐ Yes ☐ No	Chew on one side of mouth	☐ Yes ☐ No	Mouth breathing
☐ Yes ☐ No	Cigarette, pipe, cigar smoking	☐ Yes ☐ No	Orthodontic treatment
☐ Yes ☐ No	Clicking or popping jaw	☐ Yes ☐ No	Pain around ear
☐ Yes ☐ No	Dry mouth	☐ Yes ☐ No	Periodontal treatment
☐ Yes ☐ No	Fingernail biting	☐ Yes ☐ No	Sensitivity to cold, heat, or sweets
☐ Yes ☐ No	Food collection between teeth	☐ Yes ☐ No	Sensitivity when biting
☐ Yes ☐ No	Grinding teeth	☐ Yes ☐ No	Sores or growths in mouth
How often do you brush?		How often do you floss?	
How often do you have your teeth cleaned?			

Questions relating to the teeth, gums and soft tissue:			
Do you eat snacks or drink beverages containing sugar between meals 4 or more times per day?			☐ Yes ☐ No
Do you drink flouridated water or use fluoride supplements?			☐ Yes ☐ No
Do you use non-prescription fluoride products (fluoride toothpaste or rinses)?			☐ Yes ☐ No
Do you have any special health care needs that might interfere with good home care?			☐ Yes ☐ No
Have you used xylitol (sugar substitute in mints & gums) products 4x daily for the last 6 months?			☐ Yes ☐ No
Have you used calcium & phosphate toothpaste during the last 6 months?			☐ Yes ☐ No
Do you use recreational drugs?	☐ Yes ☐ No	Do you consume alcohol?	☐ Yes ☐ No
If you answered yes to the previous question, please answer the following:			
What is the average number of drinks consumed in the past year?			
☐ Less than 1 drink per day ☐ 1 drink per day ☐ 2 drinks per day ☐ 3 or more drinks per day			
Have you ever smoked cigarettes or cigars?		☐ Yes ☐ No	
If you answered yes to the previous question, please answer the following:			
How many cigarettes or cigars are/were you smoking per day?		☐ 0-9 per day	☐ 10+ per day
How many years did you or have you smoked?		☐ 0-9 years	☐ 10+ years
If you quit, how many years ago did you quit smoking?		☐ 0-9 years ago	☐ 10+ years ago
Have you ever used smokeless tobacco?			☐ Yes ☐ No
If you answered yes to the previous question, please answer the following:			
How often is or was smokeless tobacco used?		☐ Use occasionally	☐ Use daily
How many years did you or have you used smokeless tobacco?		☐ 0-9 years	☐ 10+ years
If you quit, how many years ago did you quit using smokeless tobacco?		☐ 0-9 years ago	☐ 10+ years ago