Dental History

1. Please state briefly the reason for your visit_____

	Yes	No
2. Do you have discomfort in your mouth now?……..		
3. How long has it been 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 and cold?……		
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 ever 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