DENTAL HISTORY Name: _____

1. How long since your last dental appointment? _____
   What was done? _____
   Why did you change dental offices? _____

2. Anything about dental visits that particularly bothers you? _____

3. What concerns might keep you or have kept you in the past from having dental treatment completed?
   (Check any that apply)
___ Fear or anxiety regarding treatment
___ Cost of dental treatment
___ Missing work time or too busy
___ Don't care much about my teeth
___ Lack of trust in the dentist
___ Other _____

4. Do you now or have you ever had any of the following? (Check any that apply)

___ Frequent headaches
___ Muscle soreness in your head or neck
___ Difficulty in opening or closing you jaw
___ Clicking or popping noise in your jaw joint
___ Injury to your jaw or face
___ Pain or discomfort in your jaw joint
___ Jaw locking open or closed
___ Changes in your bite
___ Teeth shifting or moving
___ Teeth sensitive to ___Hot ___ Cold___Sweets
___ Teeth sensitive to biting
___ Worn teeth
___ Loose teeth
___ Broken teeth
___ Do you clench or grind teeth
___ Sore teeth or jaw muscles in the morning

5. Do your gums ever bleed? ___ Yes ___ No
   Have you been treated for gum disease? ___ Yes ___ No
   Any areas where food catches between your teeth? ___Yes ___ No
   How often do you brush? _____ Floss? _____

6. ___ Yes ___ No Any lumps or swelling in your head, neck, or mouth?
   ___ Yes ___ No Have you had orthodontics (Braces) if yes, how long ago? _____
   ___ Yes ___ No Do you still have wisdom teeth?
   ___ Yes ___ No Do you have missing teeth besides wisdom teeth?
   ___ Yes ___ No Do you have a denture or partial denture? If yes, how old is it? _____

7. If you could change anything about your smile, what would it be? _____

_____

8. ___ Yes ___ No Is keeping your teeth for a lifetime important to you?
   ___ Yes ___ No Have you had regular cleaning appointments in the past?
   ___ Yes ___ No Have you followed through with recommended dental treatment in the past?
   ___ Yes ___ No Do you strive to have a healthy lifestyle through proper nutrition and exercise?
   ___ Yes ___ No Do you smoke or use chewing tobacco?

9. My present state of oral health is: ___ Excellent ___ Good ___ Poor
   I would like my level of oral health to be: ___ Excellent ___ Good ___ Don't really care

10. What is your **main** dental concern or problem at this time? _____

(OFFICE USE ONLY) Pertinent dental history_____

_____