Adult Dental History

Patient Name: _____ DOB: _____
Reason for Visit: _____
Date of last Dental Visit? _____ Last Cleaning? _____ X-Rays? _____
Name of previous Dentist?_____
Address: _____
Street Name City State Zip Code
How often do you get a dental exam?_____
How often do you brush your teeth? _____ Do you use Dental Floss? _____
What other dental aids do you use? (Ex. Mouthwash, Interplak, Toothpick, etc.) _____
Do you have any dental problems? Yes No
If yes, please describe _____

Are your teeth sensitive to:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently have cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	**Yes**	**No**
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed a loose tooth or change in your bite?	Yes	No
Does food tend to get stuck between your teeth?	Yes	No

If yes, where? _____

Have you ever had:

Orthodontic Treatment (Braces)?	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment (Treatment for your gums)?	Yes	No
Your teeth ground or adjusted?	Yes	No
A serious injury to the mouth or head?	Yes	No

If yes, please describe the cause _____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (Joint, Ear, and/or side of face?	Yes	No
Difficulty in chewing on either side of mouth?	Yes	No
Headaches, neck aches, or shoulder aches?	Yes	No
Sore muscles (Neck, shoulder)?	Yes	No

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (Pencils, nails, etc.)	Yes	No
Breathe through mouth while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/Chew Tobacco?	Yes	No
Are you satisfied with the appearance of your teeth?	**Yes**	**No**
Would you like to keep your teeth for the rest of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe _____
Is there anything else about having dental treatment that you would like us to know?
_____

For office use only:
Dentist Signature: _____ **Date: _____**