

Patient Name
Medical Alert

Dental History

*Welcome! So that we may provide you with the best possible care
Please complete both sides of this medical/dental history form.
All information is completely confidential.*

What is the primary reason for your visit today? _____ **What questions or concerns would you like us to answer?** _____
What was the date of your last dental visit? _____ **Last Dental Cleaning?** _____ **Last X-rays?** _____
Do you know what kind of Xrays you had recently (within the last year)? _____
 What was done at your last dental visit? _____

Previous or referring Dentist's name _____ Telephone # _____
 Address _____ email? _____

Generally, how often have you had dental examinations? _____ **Teeth cleaning?** _____
 How often do you brush your teeth? _____ How often do you floss? _____ What other dental aids do you use? (sonic brush, special brushes, rinses, special toothpastes, toothpicks, etc.) _____

Do you feel you have any dental problems now? Yes No If yes, please briefly describe, listing in order of importance:

Are any of 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 get sores or blisters of the mouth?	Yes	No
Do your gums bleed /hurt on flossing?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite or facial Expression?	Yes	No
Have the spaces between your teeth changed?	Yes	No

If yes, where? _____

Do you:

Clench/grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No
If yes, how long? _____ years	Packs Per Day _____	
Routinely get 7-8 hours of sleep?	Yes	No
Wake feeling rested and refreshed?	Yes	No
Fall asleep easily during the day?	Yes	No
Snore or have someone tell you that you snore?	Yes	No
Wake with a headache in the morning?	Yes	No
Have been told by someone that you struggle with breathing while you sleep?	Yes	No
If so, have you been diagnosed with sleep apnea?	Yes	No
Are you currently using a CPAP?	Yes	No
Satisfied with CPAP?	Yes	No
Would you be interested in an alternative to CPAP?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
If yes when? _____		
Oral Surgery?	Yes	No
If yes please describe _____		
Periodontal treatment?	Yes	No
If yes please describe _____		
Your teeth ground or the bite adjusted?		Yes
No		
A bite plate, splint, or mouth guard?	Yes	No
A serious injury to the mouth or head injury?	Yes	No
If yes please describe _____		

Have you ever experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing (please circle which) the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No

If you could change something about the appearance of your teeth what would it be? Color ___ Size ___ Shape ___ Position (straightness) ___
 Other please describe _____

On a scale of 1-10 (10 being highly important) how important is it for you to keep all of your teeth the rest of your life?
 1 _ 2 _ 3 _ 4 _ 5 _ 6 _ 7 _ 8 _ 9 _ 10

Do you feel nervous about having dental treatment? If so, what is your biggest concern?	Yes	No

Have you ever had an upsetting dental experience?	Yes	No
No		
If yes, please describe _____		

Is there anything else about your past dental care or future dental treatment that you would like us to know?
