Dental History

Name:_____ Date:_____

Clinical Examination Question List

What is the reason for seeking dental care?_____

_____

Is there anything about having dental treatment that you would like us to know? ☐YES ☐NO

If YES, please describe_____

_____

_____

Date of Last: Dental Visit _____ **Dental Cleaning** _____ **X-Rays** _____

What treatment was done at your last dental visit? _____

Previous Dentist's Name:_____ Telephone Number: _____

Address:_____City:_____ State:_____ Zip:_____

How often do you have dental examinations? _____

How often do you floss? _____ What other dental aids do you use? _____

Have you whitened your teeth before? ☐Yes ☐No What was the outcome?_____

Are you currently bleaching your teeth? ☐Yes ☐No If yes, what type? _____

Circle 'YES' or 'NO' for EACH ITEM

Do You:

Clench your teeth while awake or asleep? Yes No

Grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly?.....Yes No

Hold objects between your teeth?.....Yes No
(pencils, pipe, nails, fishing line)

Mouth breath while awake or asleep?.....Yes No

Have tired jaw muscles?.....Yes No
☐AM ☐PM ☐BOTH

Smoke/Chew tobacco?.....Yes No
How often?_____

Have you ever had:

Orthodontic (braces) Treatment?.....Yes No

Oral Surgery?.....Yes No

Periodontal (gums) Treatment?..... Yes No

Your teeth ground or your bite adjusted? Yes No

A bite plane or a mouth guard?.....Yes No

A serious injury to the mouth or head?.....Yes No
If yes, please describe, including cause:
_____

Any teeth sensitive to:

Cold ….....Yes No

Hot ….....Yes No

Sweet ….....Yes No

Pressure ….....Yes No

Have you noticed any mouth odors? …...Yes No

or bad taste?.....Yes No

Do you get sores in you mouth?.....Yes No
If yes, how often?_____

Do your gums bleed or hurt?.....Yes No

Have your parents experienced gum disease or tooth loss?.....Yes No

Have you noticed a change in your bite or the way your teeth fit together?.....Yes No

Do you chew evenly on both sides of your mouth? ….....Yes No

Does food tend to get caught between your back teeth? ….....Yes No

Have you ever experienced:

Clicking or popping of the jaw? ….....Yes No

Pain (joints, ears, side of face).....Yes No

Difficulty in opening or closing? ….....Yes No

Headaches, neck aches, shoulder aches... Yes No

Sore muscles (neck or shoulders).....Yes No

Have you had any difficult extractions? Yes No

Have you ever had prolonged bleeding after extractions?.....Yes No

Do you like the color of your teeth?.....Yes No

Do you like the shape and position of your teeth? ….....Yes No

Do you feel nervous about having dental treatment? ….....Yes No
If yes, what is your biggest concern?_____
_____

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

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