

Name: _____

Patient Dental History

When was your last Dental Visit? _____

Who was your last Dentist? Please write name, address and phone number if available.

How would you rate your last Dental experience? Good ____ Fair ____ Poor ____

When was your last Dental Cleaning? _____

When were your last Dental X-rays taken? _____

How would you rate your current dental health? Good ____ Fair ____ Poor ____

How would you rate your current anxiety level when visiting the dentist?

Extremely Anxious ____ Slight Anxiety ____ Comfortable ____

	Yes	No
Have you ever had oral hygiene instructions?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a tooth or multiple teeth that hurt when chewing?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>
Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a biopsy inside your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced clicking or popping in your jaw joint?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience a grating noise from your jaw joint when opening or closing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced pain around your jaw joint?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had your jaw locked open or closed?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had difficulty opening your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been treated for TMJ issues?	<input type="checkbox"/>	<input type="checkbox"/>
If so, how was it treated? _____		
Do you have frequent headaches? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, please describe location the best you can. _____		
Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain from any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear Removable Dentures?	<input type="checkbox"/>	<input type="checkbox"/>
How do they fit and feel? _____		
Do you have Dental Implants?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal treatment?	<input type="checkbox"/>	<input type="checkbox"/>

If you have any other dental concerns you would like to have addressed please describe here.

Thank you!