



PATIENT DENTAL HISTORY

Are you having any dental discomfort at this time? Yes No

Please describe: _____

Are your teeth sensitive: Hot only Cold only Both hot & cold When biting & chewing

On a scale of 1-10 please circle the number which best describes your discomfort 10 being the worst:



1

2

3

4

5

6

7

8

9

10

Please check all the conditions that apply:

<input type="checkbox"/> swelling or lumps in mouth	<input type="checkbox"/> bad taste
<input type="checkbox"/> grinding or clenching	<input type="checkbox"/> previous gum surgery- Year: _____
<input type="checkbox"/> bleeding gums	<input type="checkbox"/> temple headaches
<input type="checkbox"/> nasal obstruction	<input type="checkbox"/> wisdom teeth present
<input type="checkbox"/> bad breath	<input type="checkbox"/> popping or clicking in jaw joint
<input type="checkbox"/> previous orthodontics- year braces came off: _____	<input type="checkbox"/> wear dentures
<input type="checkbox"/> previous trauma to head or mouth	<input type="checkbox"/> earaches
	<input type="checkbox"/> chew lip, tongue, fingernails, pencils, pens

How often do you usually visit a dentist? _____

How long has it been since you have seen a dentist? _____

Reason for leaving previous dentist: _____

Do you have a fear of having dentistry done? Yes No

If yes please explain why: _____

Main reason for today's visit: _____

How do you feel about your teeth? Do you like your smile, color, and look? _____