

PATIENT DENTAL HISTORY

PATIENT'S NAME: _____

	<u>YES</u>	<u>NO</u>
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"/>
Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>
Do any of your teeth feel painful?	<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 had any head, neck, or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced any of the following problems —		
Clicking in your jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint,ear,side of face)?.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing your jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any loosening of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Does food tend to become caught between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had periodontal treatment (gums)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any prolonged bleeding following an extraction?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any dental implants?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures or partials?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you worried about receiving dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU COULD CHANGE **ANYTHING** ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?
