Patient Dental History

Date (D/M/Y):_____

Patients name:_____ Date of birth (D/M/Y):_____

Reason for visit:_____ Last dental visit/checkup:_____

Last dental cleaning:_____ Frequency of cleanings:_____

Have you had any xrays in the last 2 years: □ YES □ NO

Current Dentists name, address & phone:_____

Are you currently seeing a dental specialist? □ YES □ NO Specialist:_____

Do you want a copy of previous records/xrays to be forwarded here?_____

Current oral hygiene habits (brush,floss etc)?_____

Is your sugar intake: □ HIGH □ MEDIUM □ LOW

Are your teeth sensitive? □ TO HOT □ TO COLD □ TO SWEETS □ TO PRESSURE

Please check YES or NO to the following:

Do your gums bleed when you brush or floss?	□ YES	□ NO
Do you have acute and constant pain with your teeth?	□ YES	□ NO
Do you have any lumps or lesions in your mouth?	□ YES	□ NO
Have you ever had head, neck or jaw injuries?	□ YES	□ NO
Do you clench or grind your teeth during the day/night?	□ YES	□ NO
Do you have any issues with your jaw including: Clicking, popping, locking, pain in the joint, ear or side of face, difficulty to open/close or limited opening, difficulty chewing	□ YES	□ NO
Do you bite your lips or cheeks frequently (habit)?	□ YES	□ NO
Are you a mouth breather, mouth open when you sleep?	□ YES	□ NO
Do you notice your teeth becoming loose?	□ YES	□ NO
Does food get caught between your teeth?	□ YES	□ NO
Do you chew on one side of your mouth?	□ YES	□ NO
Have you ever had periodontal gum treatment?	□ YES	□ NO
Do you smoke or use smokeless tobacco products?	□ YES	□ NO
Have you ever had any head and neck radiation?	□ YES	□ NO
Have you ever had instruction for the care of your of your teeth and gums?	□ YES	□ NO
Do you wear partials or dentures?	□ YES	□ NO
If yes, do they fit well?	□ YES	□ NO
When were they placed?_____		
Do you have dental implants?	□ YES	□ NO
If yes, when were they placed?_____		
Have you had orthodontic treatment (braces)?	□ YES	□ NO
If yes, when was date completed?_____		
Are you happy with the appearance of your teeth?	□ YES	□ NO
If no, what would you like to change_____		

Any immediate concern that you'd like addressed today?_____

Hygienists notes:_____