Dental History

Print Name_____Date_____

Do you have an immediate dental problem that you would like addressed first?____If so, what is this problem?_____

Have you had any problems or bad experiences with dental treatment in the past?____If so, what were they?_____

Is there something about your oral condition that you wish to change?____If so, what change would you like made?_____

If you wear upper and lower full dentures, please skip this section and go on to the last one.

	YES	NO
Are any of your teeth loose?.....	____	____
Do you floss your teeth nightly?.....	____	____
Do your gums bleed when you brush or floss?.....	____	____
Have you noticed that your gums are receding?.....	____	____
Do you smoke anything or chew tobacco?.....	____	____
Have you noticed an unexplained bad taste in your mouth or bad breath?.....	____	____
Have you ever been told that you grind your teeth while you are sleeping?.....	____	____
Are your jaws,face,neck or temples sore when you awake from sleep?.....	____	____
Do you have any problems with your jaw joints (found just in front of the ears)?.....	____	____
Are any of your teeth temperature sensitive?.....	____	____
Do you have any missing teeth that you wish to have replaced?.....	____	____
Are you satisfied with the appearance of your teeth?.....	____	____
Are you interested in having whiter teeth?.....	____	____
Are you interested in restoring your back teeth with tooth colored materials?.....	____	____
Do you think you show too much gum when you smile?.....	____	____
Are you interested in changing the shape or length of your teeth?.....	____	____
Have you had all four of your wisdom teeth removed?.....	____	____

Full denture wearers only (upper, lower or both):

Have you always had problems keeping your denture(s) in place?.....	____	____
Do you use adhesive to keep you denture(s) in place?.....	____	____
Can you chew comfortably with your denture(s)?.....	____	____
Are you continually gagged by your denture(s)?.....	____	____
Are you satisfied with the appearance of your denture(s)?.....	____	____