



the center for  
**AESTHETIC & RESTORATIVE**  
 dentistry

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## Dental History

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Reason for today's dental appointment \_\_\_\_\_

Are you having a problem which requires immediate treatment? \_\_\_\_\_

Date of last dental cleaning \_\_\_\_\_ Date of last full set of x-rays \_\_\_\_\_

Date of last dental appointment \_\_\_\_\_ What was done at that time? \_\_\_\_\_

Name of previous dentist \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Reason for leaving previous dentist: \_\_\_\_\_

**Please circle Yes or No for each item listed below:**

- |  |     |    |
|--|-----|----|
| Do you feel nervous about having dental treatment done?    | Yes | No |
| Have you ever had an upsetting dental visit?               | Yes | No |
| Would you like to keep all of your teeth all of your life? | Yes | No |

**Are any of your teeth sensitive to:      Do you use:**

- |                     |     |    |                         |     |    |                 |
|---------------------|-----|----|-------------------------|-----|----|-----------------|
| Hot or cold.....    | Yes | No | dental floss?.....      | Yes | No | _____ times/day |
| Sweets.....         | Yes | No | a soft toothbrush?..... | Yes | No | _____ times/day |
| Biting/Chewing..... | Yes | No | a waterpik?.....        | Yes | No | _____ times/day |

- |   |     |    |
|---|-----|----|
| Do your gums bleed or hurt.....                                     | Yes | No |
| Do you have any loose teeth.....                                    | Yes | No |
| Does food ever get caught between teeth.....                        | Yes | No |
| Do you bite your lips or cheek frequently.....                      | Yes | No |
| Do you hold foreign objects with your teeth (pens, pipe, etc.)..... | Yes | No |
| Do you mouth breath while awake or asleep.....                      | Yes | No |
| Do you have popping or clicking in your jaw.....                    | Yes | No |
| Do you experience pain (jaw, joint, ear or side of face).....       | Yes | No |
| Do you have difficulty opening or closing your mouth.....           | Yes | No |
| Do you have difficulty chewing on either side of your mouth.....    | Yes | No |
| Do you have tired jaws, especially in the morning.....              | Yes | No |
| Do you get tension headaches.....                                   | Yes | No |
| Do you clench or grind your teeth while awake or asleep.....        | Yes | No |

- |   |     |    |
|---|-----|----|
| Have you had any teeth removed.....     | Yes | No |
| Have you had orthodontic treatment..... | Yes | No |
| Have you had periodontal treatment..... | Yes | No |

- |  |     |    |
|--|-----|----|
| Are you happy with the color of your teeth.....      | Yes | No |
| Are you happy with the appearance of your teeth..... | Yes | No |

Please explain: \_\_\_\_\_

Signature \_\_\_\_\_