NAME _____
LAST FIRST MIDDLE DATE

*Your answers to this dental history questionnaire will help us to understand your specific dental problems, so that we may more effectively treat you with consideration for your individual needs.*

Previous Dentist _____ Specialty _____

Address _____ Phone _____

Last Dental Visit _____ Last full mouth X-rays _____

Purpose of this visit (your immediate dental concern)? _____

**Please circle YES or NO:**

1. Are you presently in pain? ..... YES NO
   ☐ Teeth ☐ Jaw ☐ Face ☐ Gums
2. Is any part of your mouth sensitive to: ..... YES NO
   ☐ Hot ☐ Cold ☐ Sweet ☐ Pressure
3. Have you ever had periodontal treatment or gum surgery? ..... YES NO
4. Have you ever been informed that you have gum problems? ..... YES NO
5. Do your gums bleed when you brush your teeth? ..... YES NO
6. Are you aware of a bad taste or odor in your mouth? ..... YES NO
7. Do you have frequent headaches and/or neckaches? ..... YES NO
8. Do you have ear pain or pain in front of the ears? ..... YES NO
9. Does your jaw make popping, clicking or grating noises? ..... YES NO
10. Are you aware that you clench your teeth during the day? ..... YES NO
11. Have you been told that you grind your teeth during the night? ..... YES NO
12. Does your jaw hurt when you open your mouth wide or take a big bite? ..... YES NO
13. Have you ever had your teeth ground to improve your bite? ..... YES NO
14. Are you dissatisfied with the appearance of your teeth ..... YES NO
    If YES, what would you most like to change? _____
    _____
15. Have you ever had an unfavorable reaction from local anesthetic, ..... YES NO
    (Novacaine, etc.)? If YES, explain _____
16. Have you ever had any trouble with any previous dental treatment? ..... YES NO
    If YES, explain _____
17. Does dental treatment make you nervous? ..... YES NO
    If YES, check: ☐ Slightly ☐ Moderately ☐ Extremely

**Please indicate which items you use daily for oral hygiene**

☐ Hard-bristle toothbrush
☐ Soft-bristle toothbrush
☐ Electric toothbrush
☐ Proxi-brush
☐ Rubber tip
☐ Dental floss
☐ Water spray
☐ Stimudents or toothpicks
☐ Other

## DENTAL HISTORY