



FAMILY DENTISTRY

## Dental History

Do you have a specific dental problem? Y N

Describe: \_\_\_\_\_

Date of last dental appointment: \_\_\_\_\_ Date of last full mouth series: \_\_\_\_\_

Date of last cleaning: \_\_\_\_\_ Do you brush or floss on a routine basis? \_\_\_\_\_

Do you think you have active decay or gum disease? Y N

Do you smoke or chew? Y N

Are you happy with your smile? Y N Explain \_\_\_\_\_

Is there anything about your teeth that you would like to change? Y N

Explain: \_\_\_\_\_

**CHECK ( ) if you have a problem with any of the following:**

- Bad Breath
- Sensitivity to hot
- Food collection between teeth
- Sensitivity to sweets
- Loose teeth/broken fillings
- Sensitivity to biting
- Sensitivity to cold
- Sores/growth in mouth

**Do you experience any of the following?**

- Clenching/Grinding
- Facial Pain
- Headaches
- Chewing Difficulties
- Jaw Joint Pain
- Clicking/popping or discomfort in the jaw
- Limited mouth opening
- Ear congestion
- Ringing in ear
- Dizziness
- Bruxism or grind
- Bleeding of the gums

\_\_\_\_\_  
Pt's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's signature

\_\_\_\_\_  
Date