

## DENTAL HISTORY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

What is the main reason for your visit today? \_\_\_\_\_

Date of last Physical Examination: \_\_\_\_\_

Date of last Dental Examination: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_

Date of last Dental X-rays: \_\_\_\_\_

Circle

Yes No Are you having pain or discomfort at this time? \_\_\_\_\_

Yes No Do you feel very nervous about having dental treatment? \_\_\_\_\_

Yes No Have you ever had a bad experience in the dental office? \_\_\_\_\_

Yes No Is there anything that you dislike about your smile? \_\_\_\_\_

Yes No Have you been a patient in the hospital during the past two years? \_\_\_\_\_

Yes No Have you been under the care of a medical doctor during the past two years? \_\_\_\_\_

Yes No Are you taking any vitamins or herbal supplements? \_\_\_\_\_

Yes No Have you ever had any excessive bleeding requiring special treatment? \_\_\_\_\_

Yes No Have you ever taken prescription Redux or Pondimin (Fen Phen)? \_\_\_\_\_

Yes No Are there now any growths or sores in or around your mouth? \_\_\_\_\_

Yes No Do you have any trouble chewing? \_\_\_\_\_

Yes No Does food catch between your teeth? \_\_\_\_\_

Yes No Do you have pain in or near your ears? \_\_\_\_\_

Yes No Do you habitually clench or grind your teeth during the day or night? \_\_\_\_\_

Yes No Have you experienced clicking or popping of your jaw? \_\_\_\_\_

Yes No Have you ever been told that you have gum problems? \_\_\_\_\_

Yes No Do you now have bleeding gums or any other gum condition? \_\_\_\_\_

Yes No Do you or your spouse snore? \_\_\_\_\_

Yes No Is there anything related to you medical or dental history that you have not indicated above? If yes, please explain: \_\_\_\_\_