DENTAL HEALTH HISTORY

1. Date of last dental visit _____

2. Are you currently experiencing any dental pain or discomfort ..... YES ❒ NO ❒

   If so, please describe _____

3. Have you ever been treated for periodontal disease (gum disease, pyorrhea)? ..... YES ❒ NO ❒

   If so, when? _____

4. Have you ever had any serious trouble associated with previous dental treatment? ..... YES ❒ NO ❒

   If so, please explain _____

5. Do you have or have you ever had any of the following?

MOUTH	YES	NO
Bleeding, sore gums	❒	❒
Unpleasant taste/ bad breath	❒	❒
Burning tongue/ lips	❒	❒
Frequent blisters, lips/ mouth	❒	❒
Swelling/ lumps in mouth	❒	❒
Ortho treatments (braces)	❒	❒
Biting cheeks/ lips	❒	❒
Clicking/ popping jaw	❒	❒
Difficulty opening or closing jaw	❒	❒

SMILE	YES	NO
Would you like to change anything about your smile	❒	❒
Have you had any cosmetic dentistry	❒	❒
Do you have any fillings or blemishes on your teeth that look bad	❒	❒
Would you like to have your teeth whiter	❒	❒

TEETH	YES	NO
Loose teeth	❒	❒
Sensitive to hot	❒	❒
Sensitive to cold	❒	❒
Sensitive to sweets	❒	❒
Sensitive to biting pressure	❒	❒
Food regularly wedge between teeth	❒	❒
Clenching/ grinding	❒	❒
Shifting of teeth	❒	❒
Change in bite	❒	❒
Dental implants	❒	❒

ORAL HYGIENE		
Do you use the following?		
Brush	❒	❒
Dental floss	❒	❒
Flouride rinse	❒	❒

Notes: _____

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient, Parent or Guardian _____ Date _____

HEALTH HISTORY UPDATE

Date	Initials	Notes
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____