

DENTAL HISTORY

PATIENT NAME _____

Reason for today's visit _____

Date of last Dental visit _____

Former Dentist _____

Date of last dental x-ray _____

Bad Breath Yes No Clench or grind teeth Yes No Orthodontic treatment Yes No

Blisters on lips or mouth Yes No Growths or sore spots in your mouth Yes No Nitrous Oxide (laughing gas) Yes No

Burning sensation on tongue Yes No Gums swollen, tender or bleeding Yes No Periodontal treatment Yes No

Chew on one side of mouth Yes No Jaw pain tiredness Yes No Sensitivity to pressure or irritants (cold, heat, or sweets) Yes No

Cigarette, pipe or cigar smoking Yes No Lip or cheek biting Yes No

Dry mouth Yes No Loose teeth or broken fillings Yes No

Food collection between teeth Yes No Mouth breathing Yes No

How often do you floss? _____

How often do you brush? _____

Have you ever had an allergic reaction or symptoms to Novocaine, local or general anesthetics? Yes No

Have you had trouble from previous dental care? Yes No