DENTAL HISTORY

PATIENT NAME: _____

REASON FOR TODAY'S VISIT: _____

FORMER DENTIST: _____ CITY/STATE: _____

DATE OF LAST DENTAL VISIT: _____ DATE OF LAST DENTAL X-RAY: _____

PLEASE CIRCLE "**YES**" OR "**NO**" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

BAD BREATH	**YES/NO**	JAW PAIN OR TIREDNESS	**YES/NO**
BLEEDING GUMS	**YES/NO**	LIP OR CHEEK BITING	**YES/NO**
BLISTERS ON THE LIPS OR MOUTH	**YES/NO**	LOOSE TEETH OR BROKEN FILLINGS	**YES/NO**
BURNING SENSATION ON TONGUE	**YES/NO**	MOUTH BREATHING	**YES/NO**
CHEW ON ONE SIDE OF THE MOUTH	**YES/NO**	MOUTH PAIN, BRUSHING	**YES/NO**
CIGARETTE, PIPE, OR CIGAR SMOKING	**YES/NO**	ORTHODONTIC TREATMENT	**YES/NO**
CLICKING OR POPPING JAW	**YES/NO**	PAIN AROUND THE EAR	**YES/NO**
DRY MOUTH	**YES/NO**	PERIODONTAL TREATMENT	**YES/NO**
FINGERNAIL BITING	**YES/NO**	SENSITIVITY TO COLD	**YES/NO**
FOOD COLLECTIONG BETWEEN THE TEETH	**YES/NO**	SENSITIVITY TO HEAT	**YES/NO**
FOREIGN OBJECTS	**YES/NO**	SENSITIVITY TO SWEETS	**YES/NO**
GRINDING TEETH	**YES/NO**	SENSITIVITY WHEN BITING	**YES/NO**
GUMS SWOLLEN OR TENDER	**YES/NO**	SORES OR GROWTHS IN YOUR MOUTH	**YES/NO**

HOW OFTEN DO YOU FLOSS? _____

HOW OFTEN DO YOU BRUSH? _____