Joyce FAMILY DENTISTRY

DENTAL HISTORY

PATIENT NAME: _____ DATE: _____

What is the reason for your visit today? _____
Previous dentist's name: _____
Date of last visit: _____ Last teeth cleaning: _____ Last x-rays: _____
How often do you brush your teeth? _____ How often do you floss? _____

Are any of your teeth sensitive to:
Hot or cold? ..... Yes ☐ No ☐
Sweets? ..... Yes ☐ No ☐
Biting or pressure? ..... Yes ☐ No ☐
Have you noticed any mouth odors or bad taste? ..... Yes ☐ No ☐
Do you frequently get cold sores, blisters, or any lesions? Yes ☐ No ☐
Do your gums bleed or hurt? ..... Yes ☐ No ☐
Does periodontal/gum disease run in your family? ..... Yes ☐ No ☐
Does food tend to become caught between your teeth? ..... Yes ☐ No ☐

Do you:
Clench or grind your teeth? ..... Yes ☐ No ☐
Have tired jaws, especially in the morning? ..... Yes ☐ No ☐
Bite your lips or cheeks while asleep or awake? ..... Yes ☐ No ☐
Mouth breath while asleep or awake? ..... Yes ☐ No ☐
Snore? ..... Yes ☐ No ☐

Have you ever experienced:
Clicking or popping of the jaw? ..... Yes ☐ No ☐
Pain? (joint, ear, side of face) ..... Yes ☐ No ☐
Difficulty opening or closing your mouth? ..... Yes ☐ No ☐
Frequent headache, neck aches, Or shoulder aches? ..... Yes ☐ No ☐

Have you ever had:
Orthodontic treatment? ..... Yes ☐ No ☐
Oral surgery? ..... Yes ☐ No ☐
Teeth removed? ..... Yes ☐ No ☐
If so, have they been replaced? ..... Yes ☐ No ☐
Fixed bridge? ..... Yes ☐ No ☐
Removable partial? ..... Yes ☐ No ☐
Complete denture? ..... Yes ☐ No ☐
Dental implants? ..... Yes ☐ No ☐
Periodontal treatment? ..... Yes ☐ No ☐
Gum surgery? ..... Yes ☐ No ☐
If so, when? _____
By whom? _____
Your teeth ground or bite adjusted? ..... Yes ☐ No ☐
A serious injury to the mouth or head? ..... Yes ☐ No ☐
If so, please explain: _____
_____

Is there anything you would like to change about your teeth? ..... Yes ☐ No ☐
If so, what? _____

Do you feel anxiety about having dental treatment? ..... Yes ☐ No ☐
Have you ever had an upsetting dental experience? ..... Yes ☐ No ☐
If yes, please describe: _____
_____
_____

I consent to the doctor's exam and necessary diagnostics for treatment including x-rays.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____