

# Dental History

## Past Experience

When was your last dental visit? \_\_\_\_\_

When was your last dental cleaning? \_\_\_\_\_

Are you satisfied with the appearance of your teeth? \_\_\_\_\_

Have you ever had an upsetting dental experience? \_\_\_\_\_

**Is there anything else you would like us to know about you or your dental history?** \_\_\_\_\_

## Dental History

	Present	Past	Never
<i>Are your teeth sensitive to:</i>			
Hot or Cold:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biting/Chewing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweets:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Have you ever had:</i>			
Orthodontic Treatment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plate or Guard:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Periodontic Treatment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral Surgery:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serious injury to your mouth or head:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## General Information

How often do you brush? \_\_\_\_\_

How often do you floss? \_\_\_\_\_

What motivated you to come see us? \_\_\_\_\_

What concerns do you have about your teeth or smile? \_\_\_\_\_

## Dental Health Habits:

Please select the answer that best describes how you are affected by each of the following habits/behaviors:

	No, Never Have	Yes, Do Currently	Did Previously
Grind Teeth:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bite Cheek:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tongue Thrust:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth Breather:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia/Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pipe use:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smokeless Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thumb/finger sucking:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toothpick :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chewing Gum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Candy:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe: \_\_\_\_\_