CHEHALEM DENTAL

Name: _____ **DENTAL HISTORY FORM**

Birthdate: _____

What is the reason for your visit today: _____
Date of your last dental visit: _____
Last dental cleaning: _____
Last Full Mouth X-rays: _____
What was done at your last dental visit: _____
Previous dentist name: _____ Telephone number: _____
How often do you brush your teeth: _____ How often do you floss: _____

Have you ever used topical fluoride: ☐ Yes ☐ No
What other dental aids do you use (i.e., waterpik, toothpick, etc): _____
Please explain any dental problem: _____
_____
Please explain any dental anxiety: _____
_____

Have you been told to take a pre-medication prior to dental treatment: ☐ Yes ☐ No

Are any of your teeth sensitive to:

Hot or cold ..... ☐ Yes ☐ No
Sweets ..... ☐ Yes ☐ No
Biting or chewing ..... ☐ Yes ☐ No
Have you noticed bad odors or taste ..... ☐ Yes ☐ No
Do you frequently have cold sores ..... ☐ Yes ☐ No
Do you gums bleed or hurt ..... ☐ Yes ☐ No
Have you noticed any loose teeth ..... ☐ Yes ☐ No
Have you noticed a change in your bite .... ☐ Yes ☐ No
Does food get caught between your teeth ☐ Yes ☐ No
If so, where? _____

Do you:

Clench or grind your teeth at night ..... ☐ Yes ☐ No
Bite your lips or cheeks regularly..... ☐ Yes ☐ No
Hold foreign objects with your teeth..... ☐ Yes ☐ No
Mouth breathe while awake or asleep..... ☐ Yes ☐ No
Have a tired jaw, especially in morning..... ☐ Yes ☐ No
Snore or have a sleeping disorder ..... ☐ Yes ☐ No
Smoke/chew tobacco ..... ☐ Yes ☐ No

Have you ever had:

Orthodontic treatment (braces) ..... ☐ Yes ☐ No
Oral surgery ..... ☐ Yes ☐ No
A partial denture..... ☐ Yes ☐ No
A complete denture ..... ☐ Yes ☐ No
Periodontal treatment ..... ☐ Yes ☐ No
Your bite adjusted..... ☐ Yes ☐ No
A mouth or night guard ..... ☐ Yes ☐ No
A serious injury to the head or mouth..... ☐ Yes ☐ No
If so, explain _____

Have you experienced:

Clicking or popping of the jaw ..... ☐ Yes ☐ No
Head pain (joint, ear, side of face, etc.) ..... ☐ Yes ☐ No
Difficulty opening or closing your mouth .. ☐ Yes ☐ No
Difficulty chewing ..... ☐ Yes ☐ No
Headaches..... ☐ Yes ☐ No

Are you satisfied with your smile..... ☐ Yes ☐ No
Do you want to keep all of your teeth ..... ☐ Yes ☐ No

Is there anything else you would like us to know? _____
_____
_____

Patient / Guardian Signature: _____ Date: _____

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