DentalWest, P.C.

DENTAL HISTORY

Patient Name _____

Primary Initial Concern

_____

_____

Previous Dentist _____ Date of last visit _____
Reason for leaving _____
Date of last cleaning _____
Date of last full mouth x-ray (Panorex)_____

How often do you visit a dentist?_____
How often do you have your teeth cleaned?_____

Have you ever had:

_____Gum disease or pyorrhea
_____Any loose teeth
_____Any gum pain or swelling
_____Bleeding when you brush
_____Food lodging between your teeth
_____Periodontal (gum) surgery
_____Instructions on tooth brushing
_____Oral Surgery
_____Endodontic (Root Canal) Therapy
_____Orthodontic Treatment
_____Treatment for TMJ problems
_____Your teeth ground or bite adjusted
_____Worn a TMJ appliance
_____Clicking or noise in your jaw
_____Pain in your jaw or ear
_____Pain during chewing
_____Pain during opening or closing
_____Difficulty in opening or closing
_____Any injury to jaw, head or neck
_____Chewing difficulty
_____History of headaches
How often: _____
_____Are your teeth sensitive to: Hot Cold Sweet
_____Do you have any of the following habits:
_____Bite your nails
When: _____
_____Hold objects with your teeth
What: _____
_____Mouth breath while awake/sleep
_____Smoke or chew tobacco
_____Drink coffee or tea

How do you feel about having dental treatment done? Have you ever had an uncomfortable dental treatment experience? Please describe:

_____

_____

How do you feel about the appearance of your teeth?_____

Do you feel it is important to keep your teeth?_____

Is there anything else you feel we should be aware of? _____