

## **DENTAL HISTORY**

Patient Name: \_\_\_\_\_

**This information is very important; please complete to the best of your ability.**

1. Do you have any pain with your teeth because of heat, cold, or sweets? yes no  
*If so, where?* \_\_\_\_\_
2. Do you have any pain in any part of your mouth or in any tooth while biting or chewing? yes no *If so, where?* \_\_\_\_\_
3. Does food catch in between your teeth? yes no *If so, where?* \_\_\_\_\_
4. Do your gums bleed when chewing or brushing or at any other time? yes no  
*If so, where?* \_\_\_\_\_
5. Do you have frequent headaches? yes no
6. Do you chew on both sides of your mouth? yes no  
*If not, why not?* \_\_\_\_\_
7. Do you have a tired feeling in your face while chewing or at the end of the day after considerable talking? yes no
8. Do you have pain around the jaw joint? yes no  
When is the pain worse? morning evening at meals
9. Have you ever had a severe blow to the head, neck, or jaw? yes no
10. Do you ever experience a burning sensation in your tongue? yes no
11. Are you in the habit of biting your nails or any other hard objects? yes no
12. Do you clench you teeth during the day? yes no  
Have you been made aware of clenching your teeth during the night? yes no
13. Do you brush your teeth vigorously or lightly?  
How often do you brush your teeth? 1/day 2/day 3 or more times/day
14. What toothpaste do you use? \_\_\_\_\_ What mouthwash if any? \_\_\_\_\_
15. Have you ever had professional instructions on home care? yes no
16. Have you ever had any teeth removed? yes no  
If so, was general or local anesthetic used?  
Which do you personally prefer? general (put to sleep) local (injection)
17. Have you ever had local anesthetic for cavity or crown preparations? yes no
18. If you have missing teeth (besides wisdom teeth and teeth removed for braces), how long have these teeth been missing? \_\_\_\_\_  
Why didn't you have them replaced? \_\_\_\_\_  
Was it ever suggested? yes no