DENTAL HISTORY QUESTIONAIRE

What is the purpose of this visit ? ☐ New patient ☐ Emergency visit ☐ Consultation

Do your teeth or gums bother you ? ☐ Yes ☐ No
If yes, please explain :

Who may we thank for referring you to our practice ? ☐ Dental professional ☐ Family or friend ☐ Colleague
Name : ☐ Yellow pages ☐ Other

Mouth	Y	N
Bleeding or sore gums		
Unpleasant taste or bad breath		
Burning tongue or lips		
Frequent blisters on the lips or mouth		
History of oral herpes		
Swelling or lumps in mouth		
Any oral habits		

Teeth	Y	N
Are you aware of any cavities		
Do you have periodontal disease		
Are your teeth sensitive to hot		
Are your teeth sensitive to cold		
Are your teeth sensitive to sweets		
Are your teeth sensitive when biting/chewing		
Do you have any loose teeth		
Have your teeth moved or drifted		

Oral Hygiene		
Do you brush your teeth		
How often:		
Do you floss your teeth		
How often:		
Do you use a mouth rinse		
Please list :		
Do you use any other oral hygiene devices		
Please list :		

TMJ (Temporomandibular joint)		
Does your jaw click or pop ?		
Do you clench or grind your teeth?		
Any pain or soreness of the jaw joints		
Do you have frequent headaches		
Do you have frequent neck/shoulder aches		
Difficulty on opening or closing of the jaw		

General

When was your last dental visit : ☐ 6 months ago ☐ last year ☐ other :

When was your last dental cleaning : ☐ 6 months ago ☐ last year ☐ other :

Have you ever had any problems or complications from previous dental treatment ? **Y N** (circle)
If yes, please explain:

Have you ever had any problems or complications with anesthesia ? **Y N** (circle)
If yes, please explain:

	Y	N	
Have you ever had nitrous oxide (laughing gas)			If yes, for what :
Have you ever had IV sedation			If yes, for what :
Have you ever had orthodontic treatment (braces)			
Have you ever had endodontic treatment (root canals)			
Have you ever had periodontal treatment (gum surgery)			

Are you happy with the appearance of your teeth ? **Y N** (circle)
If no, please describe/explain:

What is the name and location of your current / previous dentist :

Additional Comments :

Patient Name : **Date :**