ADULT DENTAL HISTORY

What made you decide to make this appointment? ______________________

When did you last visit a dentist? ______________________

What procedure was done at that time? ______________________

How often did you visit a dentist prior to your last visit? ______________________

What types of dental treatment have you done in the past? ______________________

Have you had any periodontal (gum) treatment? ______________________

Have your teeth been straightened? ________ When? ______________________

Have you lost any teeth? __________ Have they been replaced? ______________________

Are your teeth sensitive to heat? __________ To cold? __________ To sweets? ________

Have you ever been advised by a dentist to have treatment done that you have chosen not to do? _______ Please explain. ______________________

Have you ever had nitrous oxide at a dental office? ______________________

Would you prefer nitrous oxide? ________________ Headphones? ______________________

How do you take care of your teeth? ______________________

Have you noticed that your gums bleed? _________ When? ______________________

Do you have concerns about bad breath or unpleasant tastes? ______________________

Have you noticed any loosening of your teeth? ______________________

What improvements would you like to have done to your teeth? ______________________

Do you eat between meals? ________ What types of food? ______________________

Have you experienced any pain in or around your ears? ______________________

Do you hear popping, clicking, or snapping noises when you chew? ______________________

Do you have frequent headaches? ______________________

Do you clench or grind your teeth? ________ When? ______________________

Have you had any head, neck or jaw injuries? ______________________

Are you aware of any swelling or a lump in your mouth? ______________________

Is there anything else you would like to discuss about your dental health? ______________________

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