DENTAL HISTORY

NAME _____ DATE ____/____/____
Date of last dental visit ___/___/___ Name of last Dentist: _____
Reason for your last visit (or series of visits) _____
What would you like us to know about your previous experiences with your dentist? _____

In respect to any previous dental treatment have you ever:
Had nitrous oxide? ____ Had oral conscious sedation ____Ever fainted ____
Had an allergic reaction?____Had abnormal bleeding ____ Please describe any complications you have experienced during or following any dental treatment: _____

_____

How often do you brush ____ x daily Do you floss? ____ daily ____weekly ____never
Do you use an electric toothbrush? ____
How often do you drink sugary beverages?___often ___sometimes ___never (fruit juice, Gatorade, soda)
Do you habitually use gum, lifesavers, cough drops, breath mints? _____
Do your gums bleed when you brush or eat?____Does food catch between your teeth?____
Have your teeth shifted?___ Are there any sores or growths in your mouth?_____
Are there spaces between your teeth now where there were none? ____
Are your teeth flaring?___Are any of your teeth loose?___Do any of your teeth ache? ____
Are any of your teeth sensitive to heat___cold____pressure ___? Do you clench your jaws or grind your teeth?____Do you have pain or clicking in the jaw joint around your ear?____ Have your jaw muscles ever been sore? If yes, describe _____
Do you have any other dental complaints? _____
Do you love your smile?____Do you like the shape of your teeth?____Do you like the color of your teeth? ____
Is there anything about your teeth you would like to change? _____
Are you aware that silver fillings contain mercury? ____ Does that concern you? _____
Do you smoke? ___ Do you exercise? Light___moderate___heavy___
Do you take Herbs? If so, please list with amounts _____
Do you take minerals? If so, please list with amounts _____
Do you take vitamins? If so, please list with amounts _____
Do you take St.John's Wort? _____ How often? _____
Do you take Valaria? _____ How often? _____

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Signature _____ **Date** _____