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Master of Academy of General Dentistry • Fellow of Academy of Dentistry International

## Dental Health History

**INSTRUCTIONS:** *If hand writing, please fill out in **black** pen ink only.*

Are you presently changing dentists?    Yes                       No

If yes, so that we may serve you better, why are you changing dentists?

Date of last dental visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of previous dentist or place you receive dental care:

Telephone No.: (        )

What, if anything, would you like us to be aware of so that we can make your visit most pleasant?

How many times per week do you brush your teeth?

Never                       1-6                       7-13                       14 or more

How many times per week do you floss your teeth?

Never                       1-6                       7-13                       14 or more

Which of the following hygiene products do you use?

<input type="checkbox"/> Manual toothbrush	<input type="checkbox"/> Power toothbrush	<input type="checkbox"/> Denture brush
<input type="checkbox"/> Fluoride toothpaste	<input type="checkbox"/> Tartar control toothpaste	<input type="checkbox"/> Flossing aid(s)
<input type="checkbox"/> Fluoride mouth rinse	<input type="checkbox"/> Fluoride gel application	<input type="checkbox"/> Water-Pik®

Do you now have, or have you been treated in the past for the following?

<input type="checkbox"/> Gum disease / periodontal disease	<input type="checkbox"/> Tooth decay	<input type="checkbox"/> Dry mouth
<input type="checkbox"/> Headache when you wake up	<input type="checkbox"/> Injury to teeth/jaw/face	<input type="checkbox"/> Sore jaw muscles
<input type="checkbox"/> Sensitive teeth	<input type="checkbox"/> Tooth grinding or clenching	<input type="checkbox"/> Braces
<input type="checkbox"/> Painful jaw joints	<input type="checkbox"/> Crowns	<input type="checkbox"/> Mouth ulcers/sores
<input type="checkbox"/> Lumps or growths in the head/neck/mouth	<input type="checkbox"/> Open spaces between teeth	<input type="checkbox"/> Dental Implants
<input type="checkbox"/> Removal of wisdom teeth	<input type="checkbox"/> Tooth whitening/bleaching	<input type="checkbox"/> Root canal treatment
<input type="checkbox"/> Complete or partial dentures	<input type="checkbox"/> Bridges	

Have you ever experienced the following during dental treatment?

- |   |  |
|---|--|
| <input type="checkbox"/> Special Apprehension or Phobia | <input type="checkbox"/> Fainting spells                         |
| <input type="checkbox"/> Nitrous oxide / laughing gas   | <input type="checkbox"/> Unusual reactions to dental anesthetics |
| <input type="checkbox"/> Sedation with tablets          | <input type="checkbox"/> I.V. Sedation / twilight sleep          |

If you could change anything about your smile, what would you change?

Are there any special problems with your mouth or teeth that you would like for us to be aware of?

We want to know what is important to you. If you'd like more information on any of the following, please check all that apply:

- |  |  |
|--|--|
| <input type="checkbox"/> Whiter teeth                | <input type="checkbox"/> Straighter teeth                |
| <input type="checkbox"/> Stronger teeth              | <input type="checkbox"/> Replace missing teeth           |
| <input type="checkbox"/> Avoiding dental emergencies | <input type="checkbox"/> Fewer well-planned appointments |
| <input type="checkbox"/> Monthly payment plans       |  |

**For denture wearers:**

- Which type of denture do you wear?       Upper       Lower
- How many sets of dentures have you had made since the loss of your natural teeth? \_\_\_\_\_
- Do you use denture adhesive?       Upper       Lower
- Is your experience with denture adhesive?       Good       Bad       Don't use it
- How old is your current denture? \_\_\_\_\_
- How many relines have you had? \_\_\_\_\_      Date of last reline: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Are you able to eat *any* food you want with your dentures?       Yes       No
- Do you visit the dentist yearly to check your dentures and your mouth?       Yes       No
- What do you miss most about your natural teeth?

I acknowledge that I have answered these questions accurately and truthfully to the best of my knowledge. I agree to report any changes in my dental health to this practice at the earliest possible time.

Signature of patient, or parent, or guardian (responsible party): \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship to the patient: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_