DENTAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

Form completed by: _____ Relationship to patient: _____

1. When was your last visit to the dentist (approximately): _____

   What was it for: _____

2. When was your last professional dental cleaning: _____

4. Approximately when were your last dental radiographs (x-rays): _____

4. How often do you receive dental treatment, or dental hygiene care: _____

5. Are you under the care of a dental specialist? ie) an orthodontist, endodontist, prosthodontist, periodontist _____

	Yes	No	Not Sure
6. Do you have any growths or sore spots in your mouth?	☐	☐	☐
7. Have you ever been diagnosed with periodontal/gum disease?	☐	☐	☐
8. Have you ever been advised to take antibiotics prior to dental cleanings? If yes, why? _____	☐	☐	☐
9. Do you have prolonged bleeding if you cut yourself, or are you on a blood thinner? If yes, please explain? _____	☐	☐	☐
10 Do you have any present dental problems? (sore gums, sensitive teeth, bleeding, bad breath etc) If yes, please describe: _____	☐	☐	☐
11. Are you nervous during dental treatment?	☐	☐	☐
12. Do you grind or clench your teeth while awake or asleep?	☐	☐	☐
13 Have you ever had dental implants done to replace missing teeth or to hold a denture?	☐	☐	☐
14. Do you currently have dentures – full or partial?	☐	☐	☐

Do you have or have you ever experienced any of the following (please circle which ones):

- Sensitive teeth (hot or cold) • cold sores • bleeding gums when brushing • sore gums • mouth sores
- Loose teeth • dry mouth • recession • bad breath • swelling in your mouth or face area • difficulty chewing
- Sore jaw • jaw clicks or pops on opening or closing • difficulty swallowing • burning sensation
- Calculus (tartar build-up • toothache • fractured or broken filling • tooth infection (abscess)
- Yellow or discolouration of teeth • accident or injury or surgery to your face, jaw or teeth

Are you having any problems with your teeth or mouth that are not mentioned above, or is there any additional information or comments you would like to add? _____

_____

_____

Signed: _____ Date: _____

Name (print): _____

Phone # _____ Email: _____