DENTAL HISTORY

Name_____

Purpose of this dental appointment: _____

Date of last dental visit: _____ ; last dental cleaning: _____

Date of last full mouth series of X-rays: _____

Name of previous dentist: _____ ; City _____

Are any of your teeth sensitive to: (please circle) cold hot biting pressure sweets

If so, which areas? _____

_____

	(circle)	
Have you noticed any tenderness or swelling in your gums?	Y	N
Do your gums bleed during or after you brush?	Y	N
Have you been instructed about proper home dental care?	Y	N

How often do you brush?_____ floss? _____

What other dental cleaning aids or devices do you use? _____

Do you have any unpleasant odor or taste in your mouth?	Y	N
Where? _____		
Have you had teeth removed?	Y	N
Have missing teeth been replaced?	Y	N
How long? _____		
Are you wearing removable dental appliances?	Y	N
Are you aware that you may be clenching or grinding your teeth?	Y	N
Do you have any popping or clicking noises in your ear when you chew or yawn?	Y	N
Do your jaws feel tired, especially in the morning?	Y	N
Do you have pain in front of or above your ears?	Y	N
If so, which side? _____		
Do you seem to have frequent headaches, neckaches, or shoulder aches (circle)	Y	N
Have you had orthodontic treatment?	Y	N
Have you ever had a very unpleasant dental experience?	Y	N

Describe: _____

_____

Would you change anything in the appearance or function of you teeth?	Y	N

Describe: _____

_____

To the best of my knowledge, all the above answers are true and correct.

Signature _____ Date _____

Reviewed by: _____
Dentist's Signature

Robert Wong, DDS *Kanako Shimizu, DMD*