**EAST TAYLOR DENTAL, P.C.**
**DENTAL HISTORY**

| **Patient Name** | |
|---|---|
| **Date of Birth** | **Medical Alert** |

***Welcome!*** *So that we may provide you with the best possible care please complete both sides of this form. It is important that we know about your Medical and Dental History. These facts have a bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank You for taking the time to completely fill out this questionnaire!*

***What is the reason for your visit today? _____***
***Date of Last Dental Visit_____ Last Dental Cleaning_____ Full Mouth X-Rays_____***
***What was done on your last dental visit?_ _____***
***Previous Dentist's Name_____ Telephone: _____***
***Address_____ City, State, Zip _____***
***How often do you have dental examinations? _____***
***How often do you brush your teeth? _____How often do you floss? _____ _____***
***What other dental aids do you use? (Interplak, toothpick, etc.) _____***
***Do you have any dental problems now? Yes No (If yes, please describe:_____***

| ***Are any of your teeth sensitive to:*** | | |
|---|---|---|
| *Hot or cold?* | *Yes* | *No* |
| *Sweets?* | *Yes* | *No* |
| *Biting or Chewing?* | *Yes* | *No* |
| *Have you noticed any mouth odors or bad tastes?* | *Yes* | *No* |
| *Do you frequently get cold sores, blisters, or any other oral lesions?* | *Yes* | *No* |
| ***Do your gums bleed or hurt?*** | *Yes* | *No* |
| *Have your parents experienced gum disease or tooth loss?* | *Yes* | *No* |
| *Have you noticed any loose teeth or change in your bite?* | *Yes* | *No* |
| *Does food tend to become caught in your teeth?* | *Yes* | *No* |
| *If yes, where? _____* | | |
| ***Do you:*** | | |
| *Clench or grind your teeth while awake or Asleep?* | *Yes* | *No* |
| *Bite your lips or cheeks regularly?* | *Yes* | *No* |
| *Hold foreign objects with your teeth?* | *Yes* | *No* |
| *(pencils, pipe, pins, nails, fingernails)* | *Yes* | *No* |
| *Mouth breathe while awake or asleep?* | *Yes* | *No* |
| *Have tired jaws, especially in the morning?* | *Yes* | *No* |
| *Smoke or chew tobacco?* | *Yes* | *No* |
| *Have frequent heavy snoring?* | *Yes* | *No* |
| *___Which effects the sleep of others?* | *Yes* | *No* |
| *Have significant daytime drowsiness?* | *Yes* | *No* |
| *Have night time choking spells?* | *Yes* | *No* |
| *Been told that "I stop breathing" when Sleeping?* | *Yes* | *No* |
| *Gasping when waking up?* | *Yes* | *No* |

| ***Have you ever had:*** | | |
|---|---|---|
| *Orthodontic treatment?* | *Yes* | *No* |
| *Oral Surgery?* | *Yes* | *No* |
| *Periodontal treatment?* | *Yes* | *No* |
| *Your teeth ground or bite adjusted?* | *Yes* | *No* |
| *A bite plate or mouth guard?* | *Yes* | *No* |
| *A serious injury to the mouth or head?* | *Yes* | *No* |
| ***If so, please describe, including cause_____*** | | |
| ***Have you experienced:*** | | |
| *Clicking or popping of the jaw?* | *Yes* | *No* |
| *Pain? (joint, ear, side of face)* | *Yes* | *No* |
| *Difficulty opening or closing your mouth?* | *Yes* | *No* |
| *Difficulty chewing on either side of the mouth?* | *Yes* | *No* |
| ***Are you satisfied with the appearance of your teeth?*** | | |
| *Would you like to keep your teeth all of your life?* | *Yes* | *No* |
| *Do you feel nervous about having dental treatment?* | *Yes* | *No* |
| *If so, what is your biggest concern? _____* | | |
| *Have you ever had an upsetting dental experience?* | *Yes* | *No* |
| *If yes, please describe_____* | | |

***Is there anything else about having dental treatment that you would like us to know?*** ***Yes*** ***No***
_____