PATIENT:_____ Schultz Family Dentistry **DENTAL HISTORY**

DATE:_____ **MED ALERT:** _____

1 **What is the reason for your visit today?**_____

2 **Please provide Date:**

Last Dental Visit_____ Last Dental Cleaning_____ Last Full Mouth Radiographs (x-rays)_____

3 **What was done at your last visit?**_____

4 **Previous Dentist's Name**_____

Address: _____

Phone: _____

5 **How often do you have dental examinations?**_____

6 **How often do you brush your teeth?**_____ **How often do you floss?**_____

What other dental aids to you use? (Interplak, toothpick, etc)_____

7 **Please describe any immediate dental issues/ problems:**_____

8 **Please answer the following questions regarding your oral health:**

Are any of your teeth sensitive to:		
Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheek regularly?	Yes	No
Hold objects with your teeth (i.e. pens, nails, etc)?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Smoke or chew tobacco?	Yes	No
Have you ever experienced:		
Clicking or popping in your jaw?	Yes	No
Pain in your jaw joint, ear, side of face?	Yes	No
Tired jaws, especially in the morning?	Yes	No
Difficulty in opening or closing your mouth?	Yes	No
Headaches, neck aches, or shoulder aches?	Yes	No
Sore neck or shoulder muscles?	Yes	No
Mouth odors or prolonged bad tastes?	Yes	No
Cold sores, blisters or any other oral lesion?	Yes	No
Have you ever had:		
Your teeth ground or your bite adjusted?	Yes	No
A bite plate or a mouth guard?	Yes	No
A serious injury to your mouth or head?	Yes	No
Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No

Other Important Questions:		
Have your parents had gum disease or tooth loss?	Yes	No
Have you noticed loose teeth/ change in your bite?	Yes	No
Do your gums bleed or hurt?	Yes	No
Does food tend to get caught in between your teeth?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
Have you ever had an upsetting dental experience?	Yes	No
Smile Evaluation:		
Are you pleased/ confident with the way your teeth look when you smile?	Yes	No
Do you have unwanted spaces between your teeth?	Yes	No
Is there a chip or crack that you want restored?	Yes	No
Are you concerned about any discolored teeth?	Yes	No
Do you have teeth that are overlapping, out of line, or protruding?	Yes	No
Do you have missing teeth that should be replaced?	Yes	No
Could your smile be improved if your teeth were:		
Whiter?	Yes	No
Longer?	Yes	No
Shorter?	Yes	No
Wider?	Yes	No
Narrower?	Yes	No

9 **Please describe anything else about your dental health or having dental treatment that you would like us to know:**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I am aware that all information is confidential.

Patient/ Guardian Signature:_____ Date: _____