DENTAL HISTORY

Date of your last visit to a dentist ________

Reason for your lat visit (or series of visits) ____________________

Do you have any of your x-rays or dental records? Y N

In respect to any previous dental treatment have you:

1. Ever fainted? Y N
2. Had an allergic reaction? Y N
3. Had abnormal bleeding? Y N
4. Had any other complications during or following dental treatment? Y N
   If yes, describe ____
5. Do your gums bleed on brushing or eating? Y N
6. Does food catch between your teeth? Y N
7. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring or are some of your teeth becoming loose? Y N
8. Are any of your teeth sensitive to heat, cold, or pressure? Y N
9. Do you grind your teeth or clench your jaws? Y N
10. Do you have pain or clicking in the jaw joint around your ear?
11. Have your jaw muscles ever been sore? If yes, describe ________________________
12. Are there any sores or growths in your mouth? Y N
13. Do any of your teeth ache? Y N
14. Do you have any other dental complaint? Y N

NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the foregoing questions have been accurately answered.

Signature: ____ Date: ___________________

Dentist's History Review and Significant Findings:

1. Do you have problems chewing gum? Y N
2. Do you have any problem chewing bagels? Y N
3. Have your teeth changed in the last five years? Y N
4. Do you have more than one bite? Y N
5. Do you have any problem with sleeping? Y N

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