Dental Health History Form

DOB _____

Patient Name: First _____ , Last _____

What is your goal for today's visit?_____

Do you have Pain? ☐ Yes ☐ No, if Yes, where? _____

Are your teeth Sensitive to:

Hot or Cold:	☐ Present	☐ Past	☐ Never
Biting/Chewing:	☐ Present	☐ Past	☐ Never
Sweets:	☐ Present	☐ Past	☐ Never

Date of Last Dental Exam(MM/YY) _____, Date of Last X-ray(MM/YY) _____

Former Dentist _____, City & State _____, Phone _____

Previous Dentistry

Have you ever been **Pre-medicated** for dental treatment? ☐ Yes ☐ No

Have you ever had **Orthodontic** treatment? ☐ Yes ☐ No

Have you ever had **Periodontal** treatment, such as **Deep Cleaning**, or **Periodontal Surgery**? ☐ Yes ☐ No

Have you ever been treated for **TMD?** ☐ Yes ☐ No

Have you ever had a **Traumatic injury** on **Head and Neck area**? ☐ Yes ☐ No

Have you ever had **Myofacial(facial muscle) pain**? ☐ Yes ☐ No

Have you ever had an **Oral Surgery**? ☐ Yes ☐ No

If yes on the questions above, please describe(When, Where, How treated, etc…)

_____

Do you have any parafunctional habit? Please check all that applies below

☐ Bruxism(Teeth Grinding)	☐ Bite Cheek	☐ Mouth Breather	☐ Bulimia/Anorexia
☐ Cigar/Cigarette	☐ Pipe	☐ smokeless Tobacco	
☐ Toothpick/Stimulator	☐ Bite Nails	☐ Tongue Thrust	☐ Thumb Sucking
☐ Soft Drinks	☐ Candy	☐ Chewing Gum	☐ Other

How often Do you Brush(/day)? _____, How often do you floss(/day)? _____

Toothpaste _____, Mouthwash _____

I f you have any other concern or interest in your dental needs, Please Describe