

# DENTAL HISTORY

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Reason for today's visit: _____	Date of Last Dental Exam: _____	Date of Last Dental Treatment (other than a Cleaning)? _____
Previous Dentist : _____	Date of Last Cleaning: _____	
How Long were you a patient? _____ Mos/Yrs	Date of Last Dental X-rays: _____	

Please answer YES or NO to the following questions:

PERSONAL HISTORY	YES	NO
Are you fearful of dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an unfavorable experience or any complications with dental work?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had trouble getting numb or reactions to local anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had braces? Gum treatment/surgery? Teeth extracted?	<input type="checkbox"/>	<input type="checkbox"/>

SMILE CHARACTERISTICS	YES	NO
Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been disappointed with the appearance of previous dental work?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever whitened your teeth?	<input type="checkbox"/>	<input type="checkbox"/>

BITE AND JAW JOINT	YES	NO
Do you have any discomfort when chewing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience any problems with sleep or wake up with headaches or sore teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with your jaw joint? (pain, clicking, limited opening, locking)	<input type="checkbox"/>	<input type="checkbox"/>
Have you been told or do you suspect that you grind/clench your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear or have you ever worn a night guard?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed that your teeth have changed in the past few years, becoming more worn?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of an uncomfortable bite?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced any trauma to the face/jaw (a blow, a ball hitting you, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>

TOOTH STRUCTURE	YES	NO
Have you had any cavities in the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a dry mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Are any teeth sensitive to hot, cold, biting or sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a toothache, cracked filling, broken or chipped tooth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid chewing or brushing any part of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>

GUM AND BONE	YES	NO
Have you ever been treated for gum disease or have had a deep cleaning?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when brushing, flossing or eating?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed an unpleasant taste or odor in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced your gums receding away from the teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed that your teeth have become looser?	<input type="checkbox"/>	<input type="checkbox"/>
Do your parents or siblings wear dentures, have missing teeth or have periodontal disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? For how long and how many/day?	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Pine Lake Dental Care  
 22727 SE 29<sup>th</sup> Street • Sammamish, WA 98075  
 425-392-2103 • fax 425-313-9705  
[www.pinelakedentalcare.com](http://www.pinelakedentalcare.com)