horizondentalcare
Bob Johnson, DDS

Dental History

Name: _____ **Date**_____

Yes	No	Please mark yes or no to the following questions:
☐	☐	Do your gums bleed when brushing, flossing, or eating?
☐	☐	Do you have difficulty brushing or flossing an area?
☐	☐	Does food collect between your teeth?
☐	☐	Do you have a bad taste or odor in your mouth?
☐	☐	Do you have any loose teeth?
☐	☐	Do you or have you ever smoked? (packs/day___) (when did you quit?_____)
☐	☐	Have you ever been diagnosed or treated for periodontal disease?
☐	☐	Do you have toothaches, sore teeth, or dental pain?
☐	☐	Are your teeth sensitive to hot, cold, sweets, biting, or touch?
☐	☐	Do you have any broken teeth, missing fillings, or root canals?
☐	☐	Do you have soreness or pain in your jaw, ear, or side of your face?
☐	☐	Do you get frequent headaches?
☐	☐	Does your jaw ever pop, click, lock, or become fatigued or tired?
☐	☐	Do you have difficulty opening, closing, or chewing certain types of foods?
☐	☐	Do your teeth come together unevenly?
☐	☐	Have you had an injury to the head/neck, or had an auto accident?
☐	☐	Are you dissatisfied with the appearance of your teeth?
☐	☐	Do you have dental work which you consider ugly or less than ideal?
☐	☐	Do you have chips, spaces, crowded or crooked teeth that bother you?
☐	☐	Are you self-conscious of your teeth or smile?
☐	☐	Would you like to improve your smile?
☐	☐	Have you ever had any complications from past dental treatment?
☐	☐	Have you ever experienced any complications or reactions from local anesthetic?
☐	☐	Did you ever have braces or orthodontic treatment?
☐	☐	Do you have any lumps, sores, or growths in your mouth?
☐	☐	Does dental treatment cause you much worry or concern?
☐	☐	Have you ever had an unpleasant dental experience in the past?
☐	☐	Do you think your teeth are affecting your general health?