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?