



DENTAL HEALTH HISTORY

Title: Forename: Surname: Date of birth: // // Sex:

Please describe your Current Dental Problem (Describe the signs and symptoms; how long it has been going on; what attempts have been made to sort out the problem by yourself, your doctor or dentist)

We want to meet Your Expectations. So please indicate what would be a favourable outcome to your presenting problem. (An example might be "Extracting my tooth", "Recementing my crown", "Filling the hole in my tooth", "Stopping the pain".) The more information you give us the easier it will be to meet your expectations.

- If this is your first visit then please give name/location of previous dentist
If this is your first visit then please date of your last dental appointment (approx is OK)
How often do you brush?
How often do you floss?
Does your jaw make noise so that it bothers you or others?
Do you clench or grind your jaws frequently?
Do your jaws ever feel tired?
Does your jaw get stuck so that you can't open freely?
Does it hurt when you chew or open wide to take a bite?
Do you have earaches or pain in front of the ears?
Do you have any jaw symptoms or headaches upon awaking in the morning?
Does jaw pain or discomfort affect your sleep, daily routine, or other activities?
Does jaw pain or discomfort affect your appetite?
Do you find jaw pain or discomfort extremely frustrating or depressing?
Do you have a temporomandibular (jaw) disorder (TMD)?
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?
Are you unable to open your mouth as far as you want?
Are you aware of an uncomfortable bite?
Have you had a blow to the jaw (trauma)?
Are you a habitual gum chewer or pipe smoker?

Yes or No

Yes or No

- Do you gag easily?
Does food catch between your teeth?
Do you chew on only one side of your mouth?
Do your gums bleed easily?
Do your gums feel swollen or tender?
Do you prefer to save your teeth?
Do you wear dentures?
Do you have difficulty in chewing your food?
Are you apprehensive about dental treatment?
Do your gums bleed when you floss?
Are your teeth sensitive?
Do you want complete dental care?

Yes or No

- Have you had problems with previous dental treatment?
Have you ever had dental treatment from an oral surgeon?
Have you ever had dental treatment from a specialist dentist?
Have you ever had dental treatment in or requiring a visit to or stay in a hospital?
Do you avoid brushing any part of your mouth because of pain?
Have you ever noticed slow-healing sores in or about your mouth?
Are you dissatisfied with the appearance of your teeth?

- Do you feel twinges of pain when your teeth come in contact with:
Hot foods or liquids?
Cold foods or liquids?
Sour foods or liquids?
Sweet foods or liquids?

- Have you ever thought about having:
Cosmetic treatment?
Botox or facial fillers?
Orthodontics?
Implants?
Sedation?
A smile Make Over?

Please add any comments below you would like to add (things we missed or that are important to you or maybe personal/social information which is relevant to your Dental Health.)