Dental History

Patient Name _____ DOB _____

Preferred Pharmacy_____

Previous Dentist _____ How long were you a patient_____

What is your immediate concern today _____

Please answer yes or no to the following:	**Please circle**	
Have you had an unfavorable dental experience?	Y	N
Have you ever had trouble getting numb or had a reaction to local anesthetic ?	Y	N
Is there anything about the appearance of your teeth that you want to change?	Y	N
Have you ever whitened your teeth ?	Y	N
Do you have any problems chewing ?	Y	N
Do you chew ice ?	Y	N
Have your teeth changed in the last 5 years: shorter, thinner or worn	Y	N
Have you had braces, orthodontic treatment or worn a bite guard?	Y	N
Are your teeth crowding or developing spaces ?	Y	N
Do you have more than one bite? Do you squeeze to make them fit together	Y	N
Do you fall asleep or wake up with an awareness of your teeth ?	Y	N
Do you snore or have trouble breathing during sleep ?	Y	N
Is your jaw joint in pain?	Y	N
Does your jaw make sounds ?	Y	N
Do you have headaches, neck, or shoulder aches ?	Y	N
Have you had any cavities within the past few years ?	Y	N
Do you have a family history of tooth decay?	Y	N
Do you have a dry mouth?	Y	N
Are any teeth sensitive to hot, cold, biting or sweets ?	Y	N
Have you ever had a toothache or a cracked tooth ?	Y	N
Have you had any teeth removed ?	Y	N
Have you ever been diagnosed or treated for gum disease ?	Y	N
Have you noticed receding gums ?	Y	N
Is there anyone with a history of gum disease in your family ?	Y	N
Do your gums bleed?	Y	N
Do you use any of these Supplements? *(Please circle)* GINGER GINKO GINSENG GARLIC		
Are your teeth loose?	Y	N
Have you noticed any place where food traps ?	Y	N
Have you ever noticed an unpleasant taste or odor in your mouth ?	Y	N
Have you experienced a burning sensation or numbness in your mouth ?	Y	N
Have you been diagnosed with diabetes:	Y	N

Blood Sugar _____ HbA1c_____

Patient signature_____ **Date_____**