DENTAL HISTORY _____

PATIENT NAME

DATE OF LAST DENTAL EXAM:_____

DATE OF LAST FULL MOUTH X-RAY_____WHERE TAKEN_____

	yes	no
1. Have you had trouble from previous dental care?		
2. Do you have pain in your jaw or near your ears?		
3. Do you have any unhealed injuries or inflamed areas in or around your mouth?		
4. Have you experienced any growths or sore spots in your mouth?		
5. Does any part of your mouth hurt when clenched?		
6. Have you ever had Novocaine or other local anesthetic?		
7. Have you ever had nitrous oxide (laughing gas)?		
8. Have you ever had general anesthesia?		
9. Have you ever had any reaction or allergic symptoms to Novocaine, local or general anesthesia?		
10. Have you ever had any difficult extractions in the past?		
11. Have you ever had prolonged bleeding following extractions in the past?		
12. Do your gums bleed?		
13. Do you have a bad taste in your mouth or mouth odor?		
14. Have you ever had instructions on the care of your gums?		
15. Do you chew on only one side of your mouth?		
16. Do you habitually clench or grind your teeth during the night or day?		
17. Is any part of your mouth sensitive to pressures or irritants (hot, cold or sweets)?		

Is there any other problem not covered above that you would like to discuss?

_____ _____

Patient Signature Date Doctor Signature Date