WEST MONROE DENTAL

PATIENT DENTAL HISTORY

Patient's name: _____ Date of Birth: _____

Reason for Visit: _____

Last Dental Visit: _____

Previous Dentist (Name and Location): _____

Have you had a complete series of radiographs (xrays) taken? _____ If so, when_____

How often do you brush your teeth: _____ How often do you floss your teeth: _____

	Y	N
Do your gums bleed when brushing or flossing?	☐	☐
Are your teeth sensitive to hot/cold foods?	☐	☐
Do you feel pain in any of your teeth?	☐	☐
Do you have any sores in your mouth?	☐	☐
Have you had any head or neck injuries?	☐	☐
Have you experiences any of the following problem in your jaw:		
• Clicking	☐	☐
• Pain	☐	☐
• Difficultly in opening or closing	☐	☐
• Difficulty in chewing	☐	☐

	Y	N
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Does food tend to get caught between your teeth?	☐	☐
Have you ever had peridontal treatment (gum treatment)?	☐	☐
Have you worn any appliance? (denture, retainer, etc)	☐	☐
Have you had prolonged bleeding after extractions?	☐	☐
Do you wear dentures or partials?	☐	☐
• If yes, date of placement: _____		

If you could change anything about your smile, what would you change?

_____

Signature of Patient or Parent: _____ Date:_____

Signature of Doctor: _____ Date: _____

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