



Contemporary Dentistry

Dental Health History

Patient's Name: _____ Date: _____

1. Is keeping your teeth important to you? [Y] [N]
If yes, why? _____
2. When was your last cleaning? _____
3. How often do you brush? _____
4. How often do you floss? _____
5. On a scale of 1-10, 10 being the best,
Where would you rate your smile? _____ Where would you rate your oral health? _____
6. Have you experienced any of the following problems:

Bleeding Gums [Y] [N]	Sensitivity to hot or cold [Y] [N]
Bad breath or sour taste in mouth [Y] [N]	Snoring [Y] [N]
Burning sensations in mouth [Y] [N]	Food catching between teeth [Y] [N]
Soreness in jaw [Y] [N]	Grinding of Teeth [Y] [N]
Is it hard for you to open wide? [Y] [N]	Pain/ soreness around the ears,eyes,face [Y] [N]
Clicking or popping in jaw [Y] [N]	Stiff neck muscles [Y] [N]
Dry Mouth [Y] [N]	Headaches/ Migraines [Y] [N]
7. Does having dental treatment make you afraid or nervous? [Y] [N]
If yes, what specific things bother you? _____
8. Have you ever had a less than positive dental experience? [Y] [N]
If yes, what did you dislike about that experience? _____
9. If you could change anything from your smile which of the following would you want?

Whiter [Y] [N]	Straighter [Y] [N]
Replace missing Teeth [Y] [N]	Less Gum showing [Y] [N]
Excess showing of Teeth [Y] [N]	Replace old filling(s) [Y] [N]
Reshape/resize my teeth [Y] [N]	Replace chipped Teeth [Y] [N]
Close space or spaces [Y] [N]	Replace old crowns [Y] [N]
Remove Stains/ Spots on teeth [Y] [N]	Remove silver fillings [Y] [N]
10. Where do you see yourself and your overall oral health and/ or your smile in the next 5 to 10 years?
11. Please circle the following which are important to you when making your dental health decision.

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of care
What insurance covers	Health	Detailed treatment explanations
Fear or Anxiety	Comfort	Technology
12. Something fun about yourself _____
13. What do you like to do in your free time? _____