DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit_____ Date of last dental care_____

Former Dentist_____ Date of last X-rays_____

Address _____

Check (✔) if you have had experience or problems with any of the following

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth
☐ Snoring	☐ What would you change about your smile?_____	

How often do you floss? _____ How often do you brush?_____

MEDICATIONS

List any prescription or over-the-counter medications you are currently taking: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Pharmacy Name _____

Phone (_____)_____