Dental History

Patient Name: _____

Welcome! So that Ukiah Family Dentistry may provide you with the best possible care
Please complete both sides of this medical/dental history form.
All information is completely confidential.

What is the reason for your visit today?_____
Date of Last Dental Visit_____ Last Dental Cleaning_____ Last Full Mouth X-rays_____
What was done at your last dental visit?_____

Previous Dentist's Name_____
Address_____ City_____ State_____

How often do you have dental examinations?_____
How often do you brush your teeth?_____ How often do you floss?_____
What other dental aids do you use? (Sonicare, toothpick, etc.)_____
Do you have any dental problems now? Yes No
If yes, please describe_____

Are any of your teeth sensitive to:		
Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in-between your teeth?	Yes	No
If yes, where? Upr lft- Lwr lft- Upr Rt -Lwr Rt- front		
Do you:		
Clench or grind your teeth?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathes while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including _____		
Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth for all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern? _____		
Have you ever had an upsetting dental experience?	Yes	No
If yes, please describe _____		

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe_____
_____
_____

Signature of Patient/Guardian: _____ **Date:**_____