Dental History for Adolescents and Adults (rev. January 2018)

Patient Name: Birth Date: Date Created:

What name does the patient prefer to be called?

Have you seen a dental specialist (oral surgeon, periodontist, orthodontist, etc.) in the last 3 years? If yes, name and phone	Yes No	If yes	
Have you ever had a serious head or neck injury? If yes, please describe.	Yes No	If yes	
Have you had your teeth X-rayed by another dental office in the last 3 years? If yes, dentist's name and phone number.	Yes No	If yes	
Do any of your teeth hurt? Please specify.	Yes No	If yes	
Are your teeth sensitive to cold?	Yes No		
Are your teeth sensitive to chewing or biting?	Yes No		
Are your teeth sensitive to sweets?	Yes No		
Do you have an unpleasant odor or taste in your mouth?	Yes No		
Does food catch between your teeth?	Yes No		
Do you clench or grind your teeth during the day or night?	Yes No		
Do you have difficulty opening your mouth widely?	Yes No		
Does your jaw joint click or pop?	Yes No		
Have you ever had a bite plate, splint, or guard?	Yes No		
Are you a mouth breather?	Yes No		
Do you suck your finger or thumb or do you have a tongue thrust habit?	Yes No		
Have you had braces or other orthodontic treatment?	Yes No		
Do you wear removable full or partial dentures? If yes, how old are they?	Yes No	If yes	

Are you dissatisfied with the appearance of your teeth? If yes, please notewhat you wish you could change:

☐ Color ☐ Shape ☐ Spacing ☐ Crowding

Do you consume soft drinks, candy or use chewing gum on a daily basis? Yes No

How often do you brush your teeth?

☐ less than twice a day ☐ twice a day ☐ 3 times a day ☐ more than 3 times a day

How often do you floss your teeth?

☐ daily ☐ weekly ☐ almost never ☐ never

Do you use other oral care aids?

☐ none ☐ stimudents/toothpicks ☐ interdental brushes
☐ waterpik

mouthwash? If yes, type/brand.	Yes No	If yes	
other? If yes, please specify.	Yes No	If yes	

Please add anything you believe is important for the Doctor to know: