

Dental History

Date of History. _____ . Date of last dental/dental hygiene visit _____ .

Chief dental concern _____ .

Frequency of dental care _____ . Hx of speciality care _____ .

Any recent radiographs _____ . Type(s) _____ Location _____ .

Any emergency care in past 2 years _____ .

History of head and neck radiation _____ .

Any unusual reaction to dental anesthetics _____ .

History of N₂O(Laughing Gas) _____ unusual reaction _____ .

History of TM joint problems _____ Treatment _____ .

History of bruxism _____ Appliance _____ .

History of facial or jaw injuries _____ .

History of jaw surgery _____ Orthodontics _____ .

History of prolonged bleeding after dental surgery _____ .

Mouth breather _____ Snoring _____ Sleep apnea _____ .

Chew on one side _____ Reason _____ .

Chief reason for visit today _____ .

Cosmetic concerns:

What would you change about your teeth or smile _____

_____ Bleaching _____ .

