ROBISON DENTAL CARE
DENTAL HISTORY Patient name_____

Welcome! Please complete this medical/dental history form.
All information is confidential.

What is the reason for your visit today?_____

What is the date of your last dental cleaning?_____Exam_____Xrays_____

Previous Dentist Name_____Phone_____

How often do you have dental exams/ cleanings?_____
How often do you brush your teeth?_____Floss your teeth?_____
What dental aids do you use? (electric toothbrush, dental pick?)_____

Do you have any dental problems now?_____

Are any of your teeth sensitive to:

Hot or cold	Yes	No
Sweets	Yes	No
Biting or chewing	Yes	No
Noticed mouth odor or bad taste	Yes	No
Frequent Cold Sores, blisters, lesions	Yes	No
Do your gums bleed/hurt	Yes	No
Do you have loose teeth	Yes	No
Any change in your bite	Yes	No
Does food become caught between teeth	Yes	No

If yes, where_____

Do you:

Clench or grind teeth while awake or slee	Yes	No
Bite your lips or cheeks regularly	Yes	No
Hold objects in your teeth(pens, pipe)	Yes	No
Mouth breathe while awake or sleep	Yes	No
Have tired jaws, especially in a.m.	Yes	No
Snore/ sleeping disorder	Yes	No
Smoke/ chew tobacco	Yes	No

Have you ever had:

Orthodontic treatment	Yes	No
Oral surgery	Yes	No
Periodontal surgery	Yes	No
Your teeth ground or bite adjusted	Yes	No
A bite plate or mouthguard	Yes	No
Serious injury to the mouth or head	Yes	No

Please describe_____

Have you experienced:

Clicking or popping of the jaw	Yes	No
Pain(joint, ear, side of face)	Yes	No
Difficulty in opening or closing mouth	Yes	No
Difficulty in chewing on either side	Yes	No
Headaches,neckaches, shoulder aches	Yes	No
Sore muscles(neck,shoulders)	Yes	No
Satisfied with your teeth's appearance?	Yes	No
Would you like to replace silver fillings?	Yes	No
Would you like to keep all of you teeth all of your life?	Yes	No

Do you feel nervous about having dental treatment?_____ Yes No
Please describe_____
Have you ever had an upsetting dental experience?_____ Yes No
Please describe_____
Have you ever been told to take a pre-medication prior to dental treatment?_____ Yes No

Is there anything else about having dental treatment that you would like us to know?_____ Yes No

Please describe_____