SUNDENTALDESIGN
Family & Cosmetic Dentistry

DENTAL HISTORY

Patient Name (print): _____ Date: _____

1. What is your primary reason for seeking dental care?

_____

2. When was your approximate date of your last dental visit?

_____

3. When was the approximate date of your last cleaning?

_____

4. Have you been satisfied with your past dentistry?

_____

5. Have you ever had a negative dental experience? ☐Yes ☐ No if yes, please explain.

_____

6. Has the fear of discomfort prevented you from regular care? ☐Yes ☐ No if yes, please explain.

_____

How many times daily do you brush your teeth? _____ if electric toothbrush, which brand?_____

How many times daily do you floss your teeth? _____ if manual TB: soft, med, or hard bristled? Circle

Do you gag easily during dental visit?	☐ yes ☐ no	if yes, when? _____
Do you notice that your mouth is dry?	☐ yes ☐ no	
Have you had orthodontic (braces) treatment?	☐ yes ☐ no	if yes, when? _____
Do you wear an orthodontic retainer?	☐ yes ☐ no	
Have you had periodontal (gum) treatments?	☐ yes ☐ no	
Do your gums feel tender and/or bleed easily?	☐ yes ☐ no	if yes, when? _____
Do you get headaches?	☐ yes ☐ no	if yes, when? _____
Do you have problems with teeth or fillings breaking?	☐ yes ☐ no	
Are your teeth sensitive to temperature?	☐ yes ☐ no	if yes, to hold or cold _____
Are your teeth sensitive to pressure?	☐ yes ☐ no	if yes, where? _____
Are your teeth sensitive to sweets?	☐ yes ☐ no	if yes, where? _____
Do you have clicking or popping in your jaw joints?	☐ yes ☐ no	if yes, how long? _____
Do you have pain in your jaw joints?	☐ yes ☐ no	if yes, when? _____
Do you wear a night guard?	☐ yes ☐ no	if yes, why? _____
Do you grind or clench your teeth?	☐ yes ☐ no	
Are you happy with the appearance of your teeth?	☐ yes ☐ no	

Is there anything else you would like us to know about your dental history?

_____

_____