DENTAL HISTORY

Patient's Name _____ Date _____
First Middle Last

Name of your general dentist _____ Address _____

Name of your oral surgeon _____ endodontist _____

Name of your periodontist _____ prosthodontist _____

Date of your last visit to dentist _____ Frequency of check-ups _____

Frequency of brushing _____ Time of day when you brush _____

Frequency of flossing _____ Time of day when you floss _____

Type of toothbrush _____ Type of toothpaste _____

Summarize previous dental care _____

Attitude toward previous dental care _____

What is your description of the orthodontic problem _____

Attitude toward possible orthodontic treatment _____

What facial changes would you like to see, if any _____

Do you:

Bite lips	Yes___No___	Were you breast fed (age__to__)	Yes___No___
Clench teeth when awake	Yes___No___	Were you bottle fed (age__to__)	Yes___No___
Grind teeth when asleep	Yes___No___	Have you ever:	
Have any sensitive teeth	Yes___No___	Been informed of extra teeth	Yes___No___
Have bleeding or sore gums	Yes___No___	Been informed of missing teeth	Yes___No___
Have frequent headaches	Yes___No___	Consultated an orthodontist	Yes___No___
Have pain in jaw joint	Yes___No___	Had an injury to chin	Yes___No___
Have limited jaw opening	Yes___No___	Had an injury to face	Yes___No___
Hear sounds in jaw joint	Yes___No___	Had an injury to head	Yes___No___
Hear ringing in ears	Yes___No___	Had an injury to mouth	Yes___No___
Have speech problems	Yes___No___	Had an injury to teeth	Yes___No___
Mouth breathe when awake	Yes___No___	Had any baby teeth extracted	Yes___No___
Mouth breathe when asleep	Yes___No___	Had any second teeth extracted	Yes___No___
Play a musical instrument	Yes___No___	Had jaw lock open or closed	Yes___No___
Rest on chin	Yes___No___	Had previous orthodontic care	Yes___No___
Thrust tongue when swallowing	Yes___No___	Sucked a pacifier	Yes___No___
Wear partial dentures	Yes___No___	Sucked finger(s)	Yes___No___
		Sucked thumb	Yes___No___

Do you have other oral habits (biting cheeks, fingernails, ice, pencils, etc.) Yes___No___

Do you have brothers, sisters or parents who have had previous orthodontic care Yes___No___

May we request your medical and dental records if necessary Yes___No___

If yes to any of the above, please describe--when, for what, by whom, from whom, how often, what type, until what age, etc. (use back for additional space) _____

Additional comments _____

Information given by _____ Date _____
(Signature)

6/84