

# Adult Dental History

CHT# \_\_\_\_\_

Date \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Previous dentist \_\_\_\_\_ City/State \_\_\_\_\_

How often are your teeth usually examined? \_\_\_\_\_

Date/Reason for last dental visit: \_\_\_\_\_

How were previous dental experiences? \_\_\_\_\_

How often do you: Brush \_\_\_\_\_ Floss \_\_\_\_\_ Use fluorides such as Act/Prevident \_\_\_\_\_

Has there been any injuries to teeth, such as falls, blows, chips, etc.? \_\_\_\_\_

Are you unhappy with your teeth? If so, why? \_\_\_\_\_

Any discomfort/swelling today.....  No  Yes

Teeth sensitive to hot/cold/sweets....  No  Yes

Teeth sensitive to pressure/biting.....  No  Yes

Intense anxiety about dental care.....  No  Yes

Frequent mouth ulcers/cold sores.....  No  Yes

Do gums bleed easily.....  No  Yes

Have you had gum treatments.....  No  Yes

    Gum surgery.....  No  Yes

Any problems with bad breath.....  No  Yes

Any teeth extracted.....  No  Yes

Any problems after extraction.....  No  Yes

Have you seen an orthodontist...  No  Yes

Have you had braces.....  No  Yes

Do you clench/grind teeth.....  No  Yes

Any TMJ/joint discomfort.....  No  Yes

Treatment for bite/joints.....  No  Yes

Do you have frequent headaches  No  Yes

Is water a "community well".....  No  Yes

Between meals do you:

    drink beverages/soda.....  No  Yes

    eat snacks/candy.....  No  Yes

    chew gum/breath mints...  No  Yes