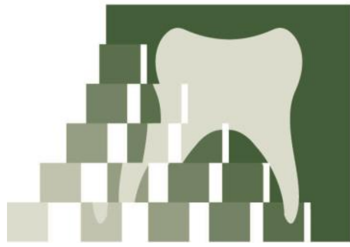

BROOKFOREST DENTAL GROUP

Patient Dental History

Name: ______________________________ Date ______________________________

Name of Previous Dentist and Location: ______________________________

Date of last exam: ____________________ Were X-rays taken? ☐ Yes ☐ No

Is there anything about your smile you would like to change or improve?…….. ☐ Yes ☐ No

If yes, what would you like to change? ______________________________

How often do you brush? ______________________________

How often do you floss? ______________________________

Do you use tobacco products? …………………………………………………. ☐ Yes ☐ No

If yes, what kind? ____________________ How frequently and for how many years? ____________________

Do your gums bleed while brushing or flossing?………………………………. ☐ Yes ☐ No

Are your teeth sensitive to hot or cold liquids/foods?………………………….. ☐ Yes ☐ No

Are your teeth sensitive to sweet or sour liquids/foods?……………………….. ☐ Yes ☐ No

Do you feel pain to any of your teeth?…………………………………………. ☐ Yes ☐ No

Do you have any sores or lumps in or near your mouth? ……………………… ☐ Yes ☐ No

Have you had any head, neck or jaw injuries? ………………………………… ☐ Yes ☐ No

Have you ever experienced any of the following problems in your jaw:

Clicking? ……………………………………………………………… ☐ Yes ☐ No

Pain (joint, ear, side of face)? ………………………………………… ☐ Yes ☐ No

Difficulty in opening or closing? ……………………………………... ☐ Yes ☐ No

Difficulty in chewing? ………………………………………………… ☐ Yes ☐ No

Do you have frequent headaches? ……………………………………………... ☐ Yes ☐ No

Do you clench or grind your teeth? ……………………………………………. ☐ Yes ☐ No

Do you bite your lips or cheeks frequently? …………………………………… ☐ Yes ☐ No

Have you ever had any difficult extractions in the past? ………………………. ☐ Yes ☐ No

Have you ever had any prolonged bleeding following extractions? …………… ☐ Yes ☐ No

Have you had any orthodontic treatment? ……………………………………… ☐ Yes ☐ No

Have you had any periodontal (gum disease) treatment? ………………………. ☐ Yes ☐ No

Do you wear dentures or partials? ……………………………………………… ☐ Yes ☐ No

If yes, date of placement ______________________________

Have you ever received instructions regarding the care of your teeth and gums? ☐ Yes ☐ No