

## Oral Hygiene History

Last Dental Visit \_\_\_\_\_

Were radiographs (xrays) taken at that visit?     Y     N

When was your last full mouth set of radiographs (xrays) taken? \_\_\_\_\_

Do you have or have you ever had any of the following: (Please mark the appropriate column)

	Currently	In the Past	Never Had
Bleeding or Sore Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste in mouth or bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning tongue or lips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent blisters on lips or mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling or lumps in mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontic treatment (braces)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biting cheeks or gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clicking or popping jaws	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of tobacco products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to hot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain while biting or chewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food caught between teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clenching or grinding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shifting of teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in bite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores, blisters or oral lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snore or have any other sleep disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Are you satisfied with your teeth's appearance?**     YES     NO

Would you like to keep all of your teeth all of your life?                                 YES     NO

Do you feel nervous about having dental treatment?                                     YES     NO

If so, what is your biggest concern? \_\_\_\_\_

Have you ever had an upsetting dental experience?                                         YES     NO

If so, please describe \_\_\_\_\_

Have you had any wisdom teeth removed?(please circle)                                     Y     N     Don't Know

How often do you use the following:                             1x/day     2x/day     3x/day

Toothbrush.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Floss.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flouride rinse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Toothbrush is: (please circle)     Soft     Medium     Hard

Have you ever been told that you have gum disease (gingivitis or periodontitis)?     Y     N

If so, in what area? \_\_\_\_\_

Any specific areas or teeth you would like us to evaluate?     Y     N

If so, where? \_\_\_\_\_

To the best of my knowledge, all of the preceding answers on both sides of this form are true and correct. If I ever have a change in my health or medications, I will inform the dentist at the next appointment.

Signature of Patient, Parent or Guardian:

\_\_\_\_\_ Date: \_\_\_\_\_