# 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 | ☐ | ☐ | ☐ |
| Unpleasant taste in mouth or bad breath | ☐ | ☐ | ☐ |
| Burning tongue or lips | ☐ | ☐ | ☐ |
| Frequent blisters on lips or mouth | ☐ | ☐ | ☐ |
| Swelling or lumps in mouth | ☐ | ☐ | ☐ |
| Orthodontic treatment (braces) | ☐ | ☐ | ☐ |
| Biting cheeks or gums | ☐ | ☐ | ☐ |
| Clicking or popping jaws | ☐ | ☐ | ☐ |
| Use of tobacco products | ☐ | ☐ | ☐ |
| Loose teeth | ☐ | ☐ | ☐ |
| Sensitivity to hot | ☐ | ☐ | ☐ |
| Sensitivity to cold | ☐ | ☐ | ☐ |
| Sensitivity to sweets | ☐ | ☐ | ☐ |
| Pain while biting or chewing | ☐ | ☐ | ☐ |
| Food caught between teeth | ☐ | ☐ | ☐ |
| Clenching or grinding | ☐ | ☐ | ☐ |
| Shifting of teeth | ☐ | ☐ | ☐ |
| Changes in bite | ☐ | ☐ | ☐ |
| Cold sores, blisters or oral lesions | ☐ | ☐ | ☐ |
| Snore or have any other sleep disorders | ☐ | ☐ | ☐ |

***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…… | ☐ | ☐ | ☐ |
| Dental Floss…… | ☐ | ☐ | ☐ |
| Flouride rinse…… | ☐ | ☐ | ☐ |
| Other…… | ☐ | ☐ | ☐ |

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: _____

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