Dental History Questionnaire

CLEAR SMILES DENTAL

Name (Last, First, M.I.) ☐M ☐F **DOB:**

Please answer the questions below. Check all that apply.

Visit History	**How often do you visit the dentist?**
	☐ Unknown ☐ Never/First Visit ☐ 1-2 per year ☐ More than twice a year ☐ Irregular ☐ Emergencies
	What was done at your last dental visit (reason for last dental visit)?
	What is the reason for your visit today?
	Do you need treatment every time you visit the dentist? ☐ Yes! ☐ Sometimes, but not always ☐ Nope
	When is that last time you had a dental cleaning? ☐ 6 months ago ☐ 1-2 years ago ☐ over 2 years ☐ Never

Current Problem	Are you in any discomfort at this time? ☐ Yes ☐ No
	How long has this condition been bothering you?
	How can we address this problem for you today?

Smile Cosmetic	What 3 things would you change about your Smile or Teeth?
	Of those 3 things which is the most important to you?
	What are the cosmetic procedures in which you are interested?

Past Experience	Do you have a fear of the dentist or dental work? ☐ Yes ☐ No
	What specifically do you dislike or fear the most?
	Are there any problems with your past dental experiences that you would like to avoid? ☐ Yes ☐ No
	Please Explain:

General History	Would you like to replace your missing teeth?
	Any Past Complications with dental work? ☐ Yes ☐ No Why?
	Have you ever had your teeth straightened (orthodontics)? ☐ Yes ☐ No
	Are your teeth sensitive to (check all applicable): ☐ Heat ☐ Cold ☐ Sweets ☐ Air
	Do you feel you have bad breath at times? ☐ Yes ☐ No
	Do your gums Bleed when you brush? ☐ Yes ☐ No How often do you brush your teeth?
	Have you ever had Gum treatments? ☐ Yes ☐ No
	Does food wedge between your teeth? ☐ Yes ☐ No Where?

TMJ/ JAWS	Do you grind or clench your teeth? ☐ Yes ☐ No Do you have pain in your Jaw joints? ☐ Yes ☐ No
	Does your Jaws pop or click? ☐ Yes ☐ No What side? ☐ Right ☐ Left
	Do you feel you have broken or chipped teeth without reason? ☐ Yes ☐ No
	Does your bite feel "off "sometimes or all of the time? ☐ Yes ☐ No
	Do you wear a night guard? ☐ Yes ☐ No Do you get frequent headaches? ☐ Yes ☐ No
	Has your Jaw ever locked open or closed? ☐ Yes ☐ No Which?

	My mouth is: ☐ Very Comfortable ☐ Moderately Comfortable ☐ Uncomfortable
	The appearance of my smile is: ☐ Excellent ☐ Satisfactory ☐ Needs Improvement ☐ Very unsatisfactory
	☐ I will do anything to keep my teeth healthy and looking great ☐ I want a healthy mouth and teeth, but only what is covered by insurance ☐ I just don't want my teeth to hurt, I don't care about health
	☐ I have set goals for my oral health with my previous dentist ☐ I want to set goals for my dental health ☐ I have never thought about goals for my dental health

On a scale of 1 to 10 below, place an "X" where your present dental health is:

1_____10
Very Poor Excellent

Place a "X" where you would like your dental health to be in 5 years.

1_____10
Very Poor Excellent

What are some additional questions about your dental health that you would like answered?

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