Dental Health History

Columbia City Dental

Name: _____

When was your last dental visit? _____ How often did you see the dentist? _____

Do you have any dental problems that require immediate attention? _____

Do any of the following cause tooth discomfort? ☐ Hot ☐ Cold ☐ Sweets ☐ Chewing

How often do you brush your teeth? _____ Floss? _____

Do your gums bleed while cleaning? _____ Do your gums feel tender or swollen? _____

Have you had periodontal gum treatment? _____ When? _____

Do you clench or grind your teeth? _____ Do your jaws feel tired or ache? _____ Click or pop?_____

Have you had your wisdom teeth removed? _____ Other oral surgery? _____

Have you had orthodontic treatment (braces)? _____ Root canal therapy? _____

Does coming to the dentist make you anxious? ☐ No ☐ Yes _____

Have you ever had an unusual reaction to dental treatment? _____

Have you ever had a serious injury to your head or mouth? _____

Do you have a latex allergy? ☐ No ☐ Yes

Do you use tobacco? ☐ No ☐ Yes If so, what kind and how much?_____

Has your doctor ever prescribed antibiotics for you to take before a dental appointment? ☐ No ☐ Yes

Do you have a panoramic x-ray or full-mouth set of x-rays less than 5 years old? ☐ No ☐ Yes ☐ Not sure

Do you have bitewing (check-up) x-rays less than 1 year old? ☐ No ☐ Yes ☐ Not sure

Signature _____ Date _____