

## DENTAL HISTORY

1. Does your child have a specific dental problem? Yes \_\_\_ No \_\_\_ Describe \_\_\_\_\_
2. Does your child have dental examinations on a routine basis? Yes \_\_\_ No \_\_\_ Last visit \_\_\_\_\_  
Last X-rays \_\_\_\_\_ Last fluoride Tx \_\_\_\_\_ Last cleaning \_\_\_\_\_
3. Would you describe their present dental health as good? Yes \_\_\_ No \_\_\_ Comments \_\_\_\_\_
4. Has he/she been treated for any gum disease (gingivitis, periodontitis, trench mouth, pyorrhea)? Yes \_\_\_ No \_\_\_
5. How often does he/she brush? \_\_\_\_\_ Floss? \_\_\_\_\_ Use mouth rinses? \_\_\_\_\_
6. Does he/she feel nervous about having dental treatment? Yes \_\_\_ No \_\_\_
7. Has he/she ever had a bad experience in a dental office? Yes \_\_\_ No \_\_\_ Describe \_\_\_\_\_  
\_\_\_\_\_
8. Does he/she ever brux or grind their teeth? Discuss \_\_\_\_\_
9. Has he/she ever had orthodontic treatment (tooth straightening)? Yes \_\_\_ No \_\_\_
10. Does he/she ever have clicking, popping or discomfort in the jaw joints (TMJ)? Yes \_\_\_ No \_\_\_ Discuss \_\_\_\_\_  
\_\_\_\_\_
11. Has he/she had a root canal or pulpotomy treatment? Yes \_\_\_ No \_\_\_
12. Has he/she ever lost a tooth due to an accident or decay? Yes \_\_\_ No \_\_\_
13. Has he/she often had toothaches? Yes \_\_\_ No \_\_\_
14. Has he/she had frequent sores in his/her mouth? Yes \_\_\_ No \_\_\_
15. Has he/she had any injuries to his/her mouth or jaw? Yes \_\_\_ No \_\_\_
16. Has he/she ever had a thumb sucking habit or used a pacifier? Yes \_\_\_ No \_\_\_ Till what age? \_\_\_\_\_
17. Do they use tobacco? Yes \_\_\_ No \_\_\_ What type? \_\_\_\_\_
18. Does he/she frequently snack on sweets, chew gum, or drink pop? Yes \_\_\_ No \_\_\_
19. What has been used for comfort in previous dental treatment?  Local Anesthetic  N20 Gas  Neither
20. Has he/she had a reaction to dental anesthetic? Yes \_\_\_ No \_\_\_
21. Have you been told they need to be pre-medicated for dental treatment? Yes \_\_\_ No \_\_\_
22. Do you have any other comments or concerns that you would like to bring to our attention? Yes \_\_\_ No \_\_\_  
\_\_\_\_\_

X \_\_\_\_\_ Date \_\_\_\_\_  
Patient Signature (Parent or Guardian)

Reviewed by Doctor \_\_\_\_\_ Date \_\_\_\_\_