Strobel Family Dentistry

Dental History

(PLEASE PRINT) Patient's Name _____ Date ___/___/_____

Please check any of the following problems that apply to you.

- ☐ Lumps/swelling in the mouth
- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Broken teeth or broken fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen, or irritated gums
- ☐ Loose, tipped, or shifting teeth
- ☐ Bad breath or bad taste in your mouth
- ☐ Dry mouth
- ☐ Viral infections and cold sores
- ☐ Head or neck injuries
- ☐ Sinus trouble

If I could change my smile, I would:

- ☐ Make my teeth brighter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match

Have you ever been instructed to take an antibiotic prior to dental treatment? ☐ YES ☐ NO

Do you smoke or use chewing tobacco? ☐ YES ☐ NO

If so, how much do you smoke/chew, and how long have you smoked/chewed?

_____

On a scale of 1–10, with 10 being the highest rating:

How important is dental health to you? 1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Please share the following dates:

Your last cleaning _____ Your last complete x-rays _____

Name of previous dentist _____

City & State of previous dentist _____

What is the most important thing to you about your dental visit today?

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