OSBORNE DENTISTRY
DENTAL HISTORY

What is the reason for your visit today?_____
_____

Date of Last Dental Visit_____ **Last Dental Cleaning** _____**Last Full Mouth X-rays**_____
What was done at your last dental visit? _____
Previous Dentist's Name _____
Address _____Telephone # _____

How often do you have dental examinations? _____
How often do you brush your teeth? _____How often do you floss?_____
What other dental aids do you use? (Interplak, toothpick, etc.)_____

Do you have any dental problems now? Yes No
If yes, please describe:_____

Are any of your teeth sensitive to:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Mouth odors or bad taste?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught between your Teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign object with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____
_____

Have you experienced:

Clicking or popping of the jaw	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in chewing on either side of your mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

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 yes, please describe _____
_____

Is there anything else about having dental treatment that you would like us to know?
If yes, please describe _____
_____