El Paso Quality Dentistry, P.A.

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## Dental History

Answers to the following questions will allow us to address your specific concerns providing the care appropriate for your particular needs.

1. What concerns do you have about your dental health or about your first visit to our practice?____________________________________________________________
2. How do your previous dental experiences affect your feelings today about having dental treatment?___________________________________________________________
3. Have you ever had an allergic reaction to ☐ anesthetic? ☐ Latex? ☐ Non-precious metals?
4. Have you ever been treated for periodontal disease (gum disease) ☐yes ☐no
5. Do you or have you ever been told to pre-medicate before treatment? ☐yes ☐no

**Do you have or have you ever had any of the following? (Please check)**

| **Mouth** | | **Teeth** | |
|---|---|---|---|
| Loose Teeth | ☐ | Bleeding, sore gums | ☐ |
| Unpleasant taste/bad breath | ☐ | Sensitive to hot | ☐ |
| Burning tongue/lips | ☐ | Sensitive to cold | ☐ |
| Frequent blister, lips/mouth | ☐ | Sensitivity to sweets | ☐ |
| Swelling/lumps in mouth | ☐ | Sensitivity to Pressure | ☐ |
| Ortho treatment (braces) | ☐ | Food Traps | ☐ |
| Biting Cheek/Lips | ☐ | Clenching/grinding teeth | ☐ |
| Clicking/popping jaw | ☐ | Change in Bite | ☐ |
| Difficulty opening/closing jaw | ☐ | Extraction/Wisdom Teeth | ☐ |
| Pain/Ringing in ears | ☐ | Headaches | ☐ |

6. How is your present dental health maintained:
   ☐Brushing___________________☐Flossing__________________☐Other_________________
   Dental Visits (Frequency and type of treatment done)
   ________________________________________________________________________
7. Is there anything you would like to enhance about the appearance of your smile?
   Color of teeth? ☐ Shape of teeth?☐ Alignment of teeth?☐
8. Have you ever thought about long-term goals in regard to the health of your mouth?
   ________________________________________________________________________
9. What barriers do you see to having your mouth as healthy as it could be?_________________
   ________________________________________________________________________
10. What else would you like us to know about you in order to serve you well?
    ________________________________________________________________________

**Patient's Name** ____________________**Signature**____________________ **Date**_________