



Dental History

Countryside Dental
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CountrysideDentist.com

Name _____ Date _____
First Mi. Last

Reason for Today's Visit _____

Date of last exam _____ Date of last dental X-rays _____

Date of your last dental cleaning _____ How often do you brush? _____

What type of toothbrush do you use? regular electric

How often do you floss? _____

Do you use mouthwash or some other type of rinse? Yes No Describe _____

Do you have any dental problems now? Yes No Describe _____

Have you ever had an upsetting dental experience? Yes No Describe _____

Have you ever had: Orthodontics Periodontal Surgery Oral Surgery

Please check any of the following conditions that apply to you:

- Bad Breath
- Grinding Teeth
- Sensitivity to Hot
- Bleeding Gums
- Loose Teeth or Broken Filling
- Sensitivity to Cold
- Clicking or Popping jaw
- Periodontal Treatment
- Sensitivity When Biting
- Food Collection between Teeth
- Sores or Growths in Your Mouth
- Sensitivity to Sweets
- Tired jaws in the morning
- Sore Facial Muscles
- Wear a Night Guard
- Difficulty in opening or closing the mouth
- Snoring
- Headaches or Neck Aches

Are you happy with the appearance of your teeth? Yes No If no, please describe

Other: _____

Previous Dentist's Name _____