HI-DESERT
FAMILY HEALTH CLINICS
HI-DESERT MEMORIAL HEALTH CARE DISTRICT

Dental History Questionnaire

Name (First, Last): _____

Date of Birth: _____ Today's Date: _____

1. Date of last dental visit? _____ Date of last x-rays? _____
2. Reason for last visit? _____
3. Do you have any dental problems now or feel pain on any teeth? ☐YES ☐NO
   If yes, please describe: _____
4. Do your gums bleed while brushing or flossing? ☐YES ☐NO
5. Are your teeth loose? ☐YES ☐NO
6. Have you ever been told you have gum disease? ☐YES ☐NO
7. Have you ever been told you have bad breath? ☐YES ☐NO
8. Are your teeth sensitive to? (circle all that apply) Sweets Cold Heat Pressure
9. Do you have any sores or lumps in or near your mouth? ☐YES ☐NO
10. Have you ever had any pain in your jaw joints (clicking/popping)? ☐YES ☐NO
11. Do you clench or grind your teeth? ☐YES ☐NO
12. Do you hold foreign objects between your teeth (pens, fingernails, pipes, etc)? ☐YES ☐NO
13. Do you wear removable or partial dentures? ☐YES ☐NO
14. Do you smoke of use tobacco? ☐YES ☐NO
    If yes, please describe _____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best care possible.

Patient Signature: _____ Date: _____