**6TH SENSE PATIENT DENTAL HISTORY**

**Print Name** _____ Date _____
**Reason for today's appointment/primary concern**:
_____
When was your last dental **exam**? _____ Reason? _____
When was your last **cleaning**? _____
When was your last full mouth set of **x-rays**? _____
Was any treatment recommended that was not completed?
_____
Have you ever had a **comprehensive plan** to help you keep your teeth? Yes _____N0_____
Are you **apprehensive** about having dental treatment done? Yes _____ No _____
If yes, please describe _____
Have you ever had an upsetting dental experience? Yes _____ No _____
If yes, please describe _____
What methods have been used in the past to assure your **comfort** while having dental care?
Local Anesthetic _____ Nitrous Oxide _____ I.V. Sedation _____ Pre-op Oral Sedative_____
Headphones _____ Pillow _____ Blanket_____ Television _____

## Please check any statements, which apply to you.

I have **pain** in my teeth when I:
_____ Eat sweets/ cold food/drinks _____Hot food/drinks _____Chew firm/hard foods
_____Food catches between my teeth _____Rough fillings catch floss or food
_____My gums are swollen and sore _____My gums bleed when I brush or floss
_____I have bad breath _____My mouth is dry most of the time
_____I breathe through my mouth _____I have pain around my ears
_____I have noise in my jaw joint _____I tend to chew on one side
_____My face muscles are tired/sore when I wake
_____I snore during sleep or have apnea _____Habit of biting fingernails/hard objects
_____I have a lump or swelling _____ I have some sore places in my mouth
I have not replaced missing teeth because: _____
_____I have noticed **loose teeth or shifted teeth** resulting in gaps between teeth

How often do you see your dentist?
_____Every 3 months _____4 months' _____6 months' _____once a year _____ only for a problem
How often do you **brush** your teeth? _____
How often do you **floss** your teeth? _____only to remove debris _____times per week
What other aids do you use (electric toothbrush, toothpick, water pick etc.)?
_____
Have you ever been told you have gum disease, **periodontal disease**? Yes ___ No ___
If yes, what treatment was rendered? _____

Have you ever had **orthodontic** treatment? Yes ____ No ___
If so, when? _____ If, so, for how long? _____Year do you wear a retainer? Yes ___ No ___

Have you ever had your teeth bleached or **whitened**? Yes _____ No _____
Are you satisfied with your smile and the appearance of your teeth? Yes _____ No _____
If you had a magic wand and could change the appearance of your teeth, what would you do?
_____
Do you wear a **mouth guard or night guard**? Yes _____ No _____
Have you ever **had a traumatic mouth, head, face or neck injury**? Yes ___ No ___
How often do you have **headaches**? _____
Do you feel, or been told, you have a **bite, TMJ, clenching, or grinding** problem? _____
What treatment has been done to alleviate the problem? _____
After treatment, my symptoms: ___disappeared ___somewhat relieved ___didn't change much ___got worse