Dental Smiles of West Loop

1202 W.Madison Street,Chicago,IL,60607 312-724-7161

DENTAL HISTORY

Name: _____

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

Are you happy with the appearance of your teeth/smile? ▫ Yes ▫ No If no, please describe_____

Previous Dentist :_____ Signature_____