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University Health Center
Dental Health History

Patient Name: Birth Date: UO ID:

HAVE YOU HAD ANY OF THE FOLLOWING?:

Dental X-rays within 12 months? Yes ☐ No ☐

History of Orthodontics? (Braces on your teeth? Yes ☐ No ☐

When was your last dental exam?

When was your last dental cleaning?

Do you have gums that bleed? Yes ☐ No ☐
If yes, please explain:

Bad Breath? Yes ☐ No ☐
If yes, please explain:

Wisdom Teeth Removed? Yes ☐ No ☐
If yes, how many and how long ago?

Root Canal? Yes ☐ No ☐
If yes, please explain:

Injury to face or jaw? Yes ☐ No ☐
If yes, please explain:

Clicking of jaw? Yes ☐ No ☐
If yes, please explain:

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Pain in Joint, Ear, Side of Face? Yes ☐ No ☐
If yes, please explain:

Clench or grind your teeth? Yes ☐ No ☐
If yes, please explain:

Is there anything about dental treatment that bothers you? Yes ☐ No ☐
If yes, please explain:

Any other concerns? Yes ☐ No ☐
If yes, please explain:

Signature of Patient, Parent or Guardian:

Date: