DENTAL HISTORY

What would you like us to do for you today?______________________________
Date of last dental visit__________Date of last x-rays______________Where?________________

Please check yes or no to the following questions

Yes	No		**Degree Of Discomfort**
☐	☐	Do you have any pain in, or around your mouth today? If yes please explain______________________	***Mild*** ***Severe*** 1 2 3 4 5 6 7 8 9 10
☐	☐	Do you have any pain in or near your ears? If yes please explain______________________	
☐	☐	Do you suffer from frequent headaches?	
☐	☐	Clicking or popping in your jaw? Does your jaw ever lock?	
☐	☐	Have you ever had any serious injury to your teeth or jaw?	
☐	☐	Do you currently wear a night guard?	
☐	☐	Do you clench or grind your teeth on a regular basis?	
☐	☐	Have you ever had any trouble associated with dental treatment? If yes please explain______________________	
☐	☐	Does dental treatment make you anxious, or nervous?	
☐	☐	Have you ever had local anesthesia (novocaine)?	
☐	☐	Have you ever had periodontal treatment?	

Do you have or have you had any of the following?

Yes	No		Yes	No	
☐	☐	Bad Breath	☐	☐	Bleeding Gums
☐	☐	Clicking or popping jaw	☐	☐	Food collecting between teeth
☐	☐	Loose teeth	☐	☐	Broken/Cracked teeth
☐	☐	Sensitivity to hot	☐	☐	Sensitivity to sweets
☐	☐	Sensitivity to cold	☐	☐	Sharp pain when biting
☐	☐	Sores or growths in your mouth	☐	☐	Shifting teeth

Aesthetic self analysis

Yes	No	
☐	☐	Are you happy with the appearance of your teeth? If no please explain______________________
☐	☐	Have you ever bleached your teeth?
☐	☐	Does your self confidence lessen when smiling in front of other people?
☐	☐	Do you ever put your hand up to cover your smile?
☐	☐	Is there someone you feel has a better smile than you?
☐	☐	Do you wish your teeth were whiter?
☐	☐	Do you wish your gums looked better?
☐	☐	I am interested in an aesthetic evaluation to determine possible aesthetic treatment