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?	Mild Severe
		If yes please explain_____	1 2 3 4 5 6 7 8 9 10
□	□	Do you have any pain in or near your ears?	
□	□	Do you suffer from frequent headaches?	
□	□	Are you aware that you snore at night?	
□	□	Are you currently being treated for Obstructive Sleep Apnea?	
□	□	Have you had 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
□	□	Gastric Reflux/GERD	□	□	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

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?
□	□	Do you wish your teeth were whiter?
□	□	Do you wish your gums looked better?