DENTAL HISTORY

Name_________________________ Date of Birth___________________________

What is the reason for your visit today?____

Date of last dental visit ___________________ Date of last dental cleaning__________________

Date of last dental x-rays__________________Type of x-rays taken________________________

Do you have any dental problems now? Yes No If yes, please explain:

____

Does dental treatment make you nervous? ____No ____Slightly ____Moderately ____Very

Is there anything else you would like us to know about your mouth, your teeth or your smile?

____

Is there anything else about receiving dental treatment that you would like us to know?

____

Are your teeth sensitive to:	**Yes**	**No**	**Have you ever had:**	**Yes**	**No**
Hot or cold?			Orthodontic treatment?		
Sweets?			Oral Surgery?		
Biting or chewing?			Periodontal treatment?		
Do your gums bleed or hurt?			Your teeth ground or the bite adjusted?		
Do you frequently get cold sores, blisters or other oral lesions?			A night guard or brux guard?		
			A serious injury to the mouth or head?		
Have you noticed any loose teeth or change in your bite?			**Have you ever experienced:**	**Yes**	**No**
			Clicking or popping of the jaw?		
Does food tend to become caught in between your teeth?			TMJ pain?		
			Difficulty opening or closing the mouth?		
Do you:	**Yes**	**No**	Headaches, neck, or shoulder aches?		
Clench or grind your teeth?			**Do you smoke or use tobacco?**		
Bite your lips or cheeks often?			Have you ever had an upsetting dental experience?		
Hold foreign objects with your teeth? (pencils, nails, etc.)			**Are you satisfied with your teeth's appearance?**		
Use a CPAP machine?					