DENTAL HISTORY

Date of last dental visit? _____ Reason? _____

What concerns you most about your teeth? _____

_____

_____

PLEASE CIRCLE YES OR NO. IF YES, PLEASE EXPLAIN

Yes No Are you presently in any dental pain?_____

_____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

_____

Yes No Are you interested in replacing any missing teeth? _____

Yes No Have your wisdom teeth been removed? _____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to the face, mouth, or teeth? _____

Yes No Have you ever been diagnosed with periodontal disease? _____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you have “tension” headaches? _____

Yes No Do you snore or been told you snore? _____

Yes No Have you ever been treated for sleep apnea? _____

Patient / Guadrian’s Signature _____ Date _____