

Dental History For: _____

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|--|---|-------|
| 1. Are your teeth sensitive to: | | |
| Heat? | Y | N |
| Cold? | Y | N |
| Sweets? | Y | N |
| Biting Pressure? | Y | N |
| 2. Does food catch between your teeth? | Y | N |
| 3. Do your gums bleed or hurt when brushing? | Y | N |
| 4. Have you noticed any gum swelling around your teeth? | Y | N |
| 5. Have you ever seen a Periodontist (gum specialist)? | Y | N |
| 6. Is there a history of gum disease in your family? | Y | N |
| 7. Do you have an unpleasant taste or odor in your mouth? | Y | N |
| 8. Do you clench or grind your teeth? | Y | N |
| 9. Do you have clicking or popping in your jaw? | Y | N |
| 10. Do you have difficulty opening or closing your mouth? | Y | N |
| 11. Has your bite ever been adjusted? | Y | N |
| 12. Have you ever been told you have a TMJ problem? | Y | N |
| 13. Do you have frequent headaches? | Y | N |
| 14. Have you had Orthodontic treatment (braces)? | Y | N |
| 15. Have you noticed any loose teeth or changes in your bite? | Y | N |
| 16. Are you concerned you will not keep your teeth for the rest of your life? | Y | N |
| 17. Are you nervous about having dental treatment or have you ever had an upsetting dental experience? | Y | N |
| Explain _____ | | |
| 18. Are you unhappy with the appearance of your teeth? If so, what would you like to change? _____ | Y | N |
| 19. Rate how you feel about your overall dental health (10 excellent – 1 poor) | | _____ |
| 20. Rate how you feel about your overall general health (10 excellent – 1 poor) | | _____ |
| 21. Are you concerned about finances required to return you mouth to excellent dental health? | Y | N |
| 22. Would you like more information about... | | |
| Teeth Whitening? | Y | N |
| Veneers? | Y | N |
| Orthodontics (Braces or Invisalign)? | Y | N |
| Tooth Replacement? | Y | N |