DENTAL HEALTH HISTORY

Are you apprehensive about dental treatment? ..... ❑ ❑
Have you had bad problems with previous dental treatment?..... ❑ ❑
Do you gag easily? ..... ❑ ❑
Do you wear dentures? ..... ❑ ❑
Does food catch between your teeth?..... ❑ ❑
Do you chew on only one side of your mouth?..... ❑ ❑
Do you avoid brushing any part of your mouth due to pain?..... ❑ ❑
Do your gums bleed easily?..... ❑ ❑
Do your gums bleed when you floss?..... ❑ ❑
Do your gums feel swollen or tender?..... ❑ ❑
Have you ever noticed slow-healing sores in or about your mouth?..... ❑ ❑
Are your teeth sensitive?..... ❑ ❑
Do you feel twinges of pain when your teeth come in contact with:
Hot foods or liquids?..... ❑ ❑
Cold foods or liquids? ..... ❑ ❑
Sours? ..... ❑ ❑
Sweets? ..... ❑ ❑
Do you take fluoride supplements?..... ❑ ❑
Are you dissatisfied with the appearance of your teeth?..... ❑ ❑
Do you prefer to save your teeth?..... ❑ ❑
Do you want complete dental care?..... ❑ ❑
How often do you brush?_____
How often do you floss?_____
Does your jaw make noise so that it bothers you or others?..... ❑ ❑
Do you clench or grind your jaws frequently?..... ❑ ❑
Do your jaws ever feel tired?..... ❑ ❑
Does your jaw get stuck so that you can't open freely?..... ❑ ❑
Does it hurt when you chew or open wide to take a bite?..... ❑ ❑
Do you have earaches or pain in front of you ears?..... ❑ ❑
Do you have any jaw symptoms or headaches upon awaking in the morning?..... ❑ ❑
Does jaw pain or discomfort affect your appetite,
sleep, daily routine, or other activities?..... ❑ ❑
Do you find jaw pain or discomfort extremely frustration or depressing?..... ❑ ❑
Do you take medications or pills for pain or discomfort?
(pain relievers, muscle relaxants, antidepressants)..... ❑ ❑
Do you have a temporomandibular (jaw) disorder (TMD)?..... ❑ ❑
Do you have pain in the face, cheeks, jaws, joints, throat or temples?..... ❑ ❑
Are you unable to open your mouth as far as you want?..... ❑ ❑
Are you aware of an uncomfortable bite?..... ❑ ❑
Have you had a blow to the jaw (trauma)?..... ❑ ❑
Are you a habitual gum chewer or pipe smoker?..... ❑ ❑
Other concerns_____

Signature of Patient_____ Date: _____

Signature of Dentist:_____ Date: _____