DENTAL HEALTH HISTORY

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

Signature of Patient____ Date: __________________

Signature of Dentist:____ Date: __________________