DENTAL HEALTH HISTORY

FORM 3 of 3

	Yes	No
Are you apprehensive about dental treatment? ____________	_	_
Have you had problems with previous dental treatment? ___	_	_
Do you **gag** easily? ______________________________	_	_
Does **food catch** between your teeth? _________________	_	_
Do you have difficulty in chewing your food? _____________	_	_
Do you chew on only one side of your mouth? ____________	_	_
Do you avoid **brushing** any part of your mouth because of pain? ______________________________	_	_
Do your gums **bleed** easily? ___________________________	_	_
Do your gums feel **swollen or tender**? ________________	_	_
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 have any teeth that spontaneously **ach or throb**? __	_	_
Do you prefer to save your teeth? _______________________	_	_
Do you want complete dental care? ______________________	_	_
Have you ever been treated by a **periodontist**? __________	_	_
If yes, when? ________________________________		
For what reason? _____________________________		
Do you have any **missing teeth** that have not been replaced? If yes, why? ________________________ ____	_	_

	Yes	No
Does your jaw…		
Ever feel tired? __________________________________	_	_
Hurt when you chew or open wide to take a bite? ______	_	_
Have pain or discomfort that affects your appetite, sleep or routine? __________________________________	_	_
Ever **pop, click or get stuck** when you open? _________	_	_
If so, how often? ____________________________		
How long has it been happening? ______________		
Do you…		
Often wake up with a **sore neck**? ___________________	_	_
Often suffer from **headaches**? ______________________	_	_
Have earaches or pain in front of the ears? ____________	_	_
Notice your teeth **wearing down** at all? ______________	_	_
Ever have pain in you **jaw muscles**? ________________	_	_
Clench or grind your teeth during the day? _____________	_	_
Know if you **grind** your teeth while you sleep? __________	_	_
Wear an **appliance** to prevent damage from nighttime grinding? If so, when was it made? __________________	_	_
Does your **bite ever feel different** when you wake up? ______	_	_
Are you a habitual gum chewer or pipe smoker? ____________	_	_
Have you ever been treated by an **orthodontist**? ___________	_	_
If yes, when? ____________________________________		
For what reason? _________________________________		
Has there been any recommended dental treatment that was **not accomplished**? If so, what prevented it? _____ ____	_	_

When was the last time you saw a dentist for a **regular checkup** (best guess)? ____

When was your last dental “**cleaning**” (best guess)? ____

How many times a year did your previous dentist recommend you have a professional “cleaning”? ___________________________

What are your future dental health **goals**? ____

What would you **change** about the appearance of your teeth if you could? ____

What has **prevented** you from making these changes? ____

On a scale of 1-10 (with 10 being the highest) what is your level of **dental anxiety**? ____

On a scale of 1-10 (with 10 being the highest) how would you rate your **current level of dental health**? _______________________

If you answered less than 10, what in your mind **keeps you from being there**? ____

Do you have a chief dental concern at this time? ____

What dental issues **not listed** would you like to discuss with the doctor? ____

Signature (Guardian if patient is a minor) ____ Date _________________