DENTAL HISTORY

Please describe your primary reason(s) for today's visit (your concerns):

1. _____

2. _____

3. _____

How long has this been going on and what would you like done? _____

_____

_____

If you could rate your smile from 1 to 10, what would it be? _____

Would you like to improve your smile? YES NO How? _____

_____

1. <u>HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING</u>:

YES	NO		YES	NO	
___	___	Clenching or grinding your teeth	___	___	Soreness or jaw pain
___	___	Clicking or popping of your jaw	___	___	Sensitivity to: **HOT** / **COLD** / **Both**
___	___	Difficulty in closing your jaw	___	___	Frequent pain to chewing
___	___	Difficulty in opening your jaw	___	___	Frequent headaches or facial pains ___daily ___weekly

2. <u>HAVE YOU EVER NOTICED ANY OF THE FOLLOWING:</u>

YES	NO		YES	NO	
___	___	Bleeding gums (gingivitis)	___	___	Your parents or spouse having periodontal or gum disease
___	___	Teeth which have become loose	___	___	Your parents or spouse losing teeth
___	___	A change in your bite	___	___	Unpleasant tastes or bad odors in your mouth
___	___	New spaces forming between your teeth	___	___	Teeth which have shifted or moved

3. <u>HAVE YOU EVER HAD</u>:

YES	NO		YES	NO	
___	___	Your bite adjusted or your teeth ground	___	___	Orthodontic treatment (braces)
___	___	Periodontal surgery and/or deep cleanings	___	___	A bite splint, bite plane or mouth guard made

Doctor's Notes: _____

_____

_____

_____