Patient Name
Medical Alert

Dental History

All information is completely confidential

What is the primary reason for your visit today?_____What questions or concerns would you like us to answer?_____
What was the date of your last dental visit?_____Last Dental Cleaning?_____Last X-rays?_____
Do you know what kind of X-rays you had recently (within the last year)?_____
What was done at your last dental visit? _____

Previous or referring Dentist's name_____ Telephone #_____
Address_____email?_____

Generally, how often have you had dental examinations?_____ Teeth cleaning?_____
How often do you brush your teeth?_____How often do you floss?_____What other dental aids do you use? (sonic brush, special brushes, rinses, special toothpastes, toothpicks, etc.)_____

Do you feel you have any dental problems now? Yes No If yes, please briefly describe, listing in order of importance:

_____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get sores or blisters of the mouth?	Yes	No
Do your gums bleed /hurt on flossing?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite or facial Expression?	Yes	No
Have the spaces between your teeth changed? Yes No If yes, where**?**_____		

Do you:

Clench/grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning? Yes No		
Smoke/chew tobacco? If yes, how long?_____years Packs Per Day_____	Yes	No
Routinely get 7-8 hours of sleep?	Yes	No
Wake up feeling rested and refreshed?	Yes	No
Fall asleep easily during the day?	Yes	No
Snore or have someone tell you that you snore?	Yes	No
Wake with a headache in the morning?	Yes	No
Have you been told by someone that you struggle with breathing while you sleep?	Yes	No
If so, have you been diagnosed with sleep apnea?	Yes	No
Are you currently using a CPAP?	Yes	No
Satisfied with CPAP?	Yes	No
Would you be interested in an alternative to CPAP?	Yes	No

Anything else you would like us to know?

Have you ever used botox or dermal fillers Yes No

Have you ever had:

Orthodontic Treatment? If yes when? _____	Yes	No
Oral Surgery? If yes please describe_____	Yes	No
Periodontal treatment? If yes please describe_____	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate, splint, or mouth guard?	Yes	No
A serious injury to the mouth or head injury? If yes please describe_____	Yes	No

_____

Have you ever experienced:

Clicking or popping of the jaw?	Yes	No
Pain in Jaw Joint, Ear or Side of Face	Yes	No
Difficulty in opening or closing (please circle which) the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance? Yes No

If you could change something about the appearance of your teeth what would it be? Color____Size_____Shape_____Position (straightness)
Other: _____

On a scale of 1-10 (10 being highly important) how important is it for you to keep all of your teeth the rest of your life?
1 2 3 4 5 6 7 8 9 10

Do you feel nervous about having dental treatment? If so, what is your biggest concern? _____ Yes No

Have you ever had an upsetting dental experience? Yes No
If yes, please describe_____

_____

Would you be interested in learning more about eliminating facial wrinkles, eye and lip lines or having lip or cheek enhancements? Yes No