Dental History

What is your immediate concern?__________________________________________________

Please answer YES or NO to the following:

**Tooth Structure and Gum Health:**
1. Have you had any cavities in the past 3 years?  
2. Do you feel or notice any hole (i.e. pitting, craters) on the biting surface of your teeth?  
3. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any areas?  
4. Do you have grooves or notches on your teeth near the gum line?  
5. Have you ever broken teeth, chipped teeth, or had a cracked tooth?  
6. Do you frequently get food trapped between any teeth?  
7. Do your gums bleed or are they painful when flossing or brushing?  
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?  
9. Have you ever noticed an unpleasant taste or odor in your mouth?  
10. Is there anyone with a history of periodontal (gum) disease in your family?  
11. Have you ever experienced gum recession?  
12. Have you ever had any teeth become loose on their own (without injury), or do you have difficulty eating an apple?  

**Bite, Jaw Joint and Sleep**
1. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)  
2. Do you feel like your lower jaw is being pushed back when you bite your teeth together?  
3. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars or other hard, dry foods?  
4. Have your teeth changed in the last 5 years, become shorter, thinner or worn?  
5. Are your teeth crowding or developing spaces?  
6. Do you have more than one bite or have to squeeze to make your teeth fit together?  
7. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habit?  
8. Do you clench your teeth in the daytime or make them sore?  
9. Have you ever worn a bite appliance or night guard?  
10. Do you have any problems with sleep or wake up with an awareness of your teeth?  
11. Do you awaken during the night and have difficulty falling back asleep?  
12. Do you awaken with a headache or a sore jaw?  
13. Do you have a dry mouth or a sore throat upon awakening?  
14. Do you snore?  
15. Do you feel groggy or tired throughout the day or fall asleep at inappropriate times?  

**Smile Characteristics:**
1. Is there anything about the appearance of your teeth that you would like to change?  
2. Have you ever felt uncomfortable about the appearance of your teeth?  
3. Do you sometimes hesitate to smile?  
4. Have you ever whitened (bleached) your teeth?  
5. Have you been disappointed with the appearance of previous dental work?