Dental History

What is your immediate concern?_____

Please answer YES or NO to the following:	YES	NO
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?	☐	☐