Dental History

Why are you seeking dental treatment at this time? ____

- Are you having any discomfort at this time?………………………………………………Yes No
- Have you ever had serious trouble with previous dental treatment?……………………….Yes No
  If so, explain____
- Does dental treatment make you nervous? No______Slightly_____Moderately_____Extremely__
- Have you used nitrous oxide (laughing gas) at the dentist before?……………………..….Yes No
  If so, did it help to reduce your anxiety? ____
- Date of last dental visit ____
- Have you ever been treated for periodontal disease (gum disease, pyorrhea)?……………..Yes No
- Have you ever had orthodontics (braces)?…………………………………………………..…Yes No
- How often do you brush? _______________________Your toothbrush is: SOFT MEDIUM HARD

Do you have, or ever had any of the following? (Circle each that apply to you)

MOUTH	**TEETH**
Bleeding, sore gums	Loose teeth
Unpleasant taste/bad breath	Sensitive to cold
Burning tongue/lips	Sensitive to hot
Frequent blisters, lips/mouth	Sensitive to sweets
Swelling or lumps in mouth	Sensitive to biting
Braces	Food impactions
Biting cheeks/lips	Clenching/grinding
Clicking/popping	Changing bite
Difficulty opening or closing jaw	

OSA SCREENING

YES NO I feel sleepy during the day, even when I get a good night's sleep
YES NO I get very irritable when I can't sleep
YES NO I often wake up at night and have trouble falling back to sleep
YES NO It usually takes me a long time to fall asleep
YES NO I usually feel achy and stiff when I wake up in the morning
YES NO I often seem to wake up gasping for breath
YES NO My bed partner says my snoring keeps him/her from sleeping
YES NO I have fallen asleep while driving

- Have you ever experienced pain or soreness in the muscles of your face or around your ear?
  YES NO
- Do you have frequent headaches, neck aches, or shoulder aches?
  YES NO
- Are you unhappy with the appearance of your teeth?
  YES NO If yes, please explain ____
- How do you feel in general? ____
- Is there anything we can do to make your visits more comfortable? _________________________

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Thank you for your cooperation in providing this information.

I CERTIFY THE ABOVE INFORMATION TO BE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. IF I EVER HAVE ANY CHANGE IN MY HEALTH OR CHANGE IN MY MEDICATION, I WILL INFORM THE DENTIST AT THE NEXT APPOINTMENT.

PATIENT SIGNATURE _________________________________ **DATE** ___________________