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
Bleeding, sore gums
Unpleasant taste/bad breath
Burning tongue/lips
Frequent blisters, lips/mouth
Swelling or lumps in mouth
Braces
Biting cheeks/lips
Clicking/popping
Difficulty opening or closing jaw

TEETH
Loose teeth
Sensitive to cold
Sensitive to hot
Sensitive to sweets
Sensitive to biting
Food impactions
Clenching/grinding
Changing bite

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? ________________________________

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 __________________