Dental History

Patient's Name_____ Birth date _____

What is the reason for your visit today?

_____

Do you have any dental problems that you are aware of? If yes, please describe

_____

_____

Date of last dental visit _____ Last dental cleaning _____ Radiographs _____

Do you feel nervous about having dental treatment? _____ If yes, what is your biggest concern?

_____

Are your teeth sensitive?_____ Do you catch food between your teeth?__

Do you have any pain in your jaw?_____ Do you grind your teeth? _____

Is there anything you would like to change about your smile? _____

Have you ever worn braces? _____ If so, when?_____ Do you wear a retainer?_____

Is bad breath a concern?_____

Do your gums bleed?_____ Have you noticed your gums receding?_____

Have you ever whitened your teeth?_____If so, where you happy with the result?_____

If not, are you interested in more information about teeth whitening? _____

Do you drink ☐ coffee ☐ tea ☐ soda? If so, how often and how much?_____

Is there anything else about having dental treatment you would like us to know? _____

If yes, please describe _____

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. For each situation, decide whether or not you would have:

No chance of dozing =0 Slight chance of dozing =1 Moderate chance of dozing =2 High chance of dozing =3

- Sitting and reading ____
- Watching TV ____
- Sitting inactive in a public place (e.g., a theater or a meeting) ____
- As a passenger in a car for an hour without a break ____
- Lying down to rest in the afternoon ____
- Sitting and talking to someone ____
- Sitting quietly after a lunch without alcohol ____
- In a car, while stopped for a few minutes in traffic

Total Score = _____