Dental History

Patient's Name_____ Birth date _____

What is the reason for your visit today?

_____

Are you aware of or concerned with any dental problems in or around your mouth? **Y N**
If yes, please describe: _____

_____

Date of last dental visit _____Do you feel nervous about having dental treatment? **Y N**
If yes, what is your biggest concern?_____

Is there any place in your mouth that is a food trap? **Y N** If yes, please describe:_____

_____

Do you grind your teeth? **Y N** Is there anything you would like to change about your smile? **Y N**
If yes, please describe: _____

Have you ever worn braces? **Y N** If yes, when? _____ Do you wear a retainer? **Y N**
Is bad breath a concern? **Y N** Do your gums bleed? **Y N**
Have you noticed your gums receding? **Y N**
Are your teeth sensitive? **Y N** Do you suffer from TMJ pain, headaches, sinus problems, or migraines? (please circle)
Have you ever whitened your teeth? **Y N** If yes, how do you feel about the result?_____

_____

If not, are you interested in more information about teeth whitening? **Y N**

Do you drink **coffee tea soda**? (please circle) If yes, how often **and** how much?

_____

Is there anything else about having dental treatment you would like us to know? **Y N**
If yes, please describe _____

Are you at risk for Sleep Apnea?

Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?
Yes No
Do you often feel TIRED, fatigued, or sleepy during daytime?
Yes No
Has anyone OBSERVED you stop breathing during your sleep?
Yes No
Do you have or are you being treated for high blood PRESSURE?
Yes No