Dental Health History

Do you have or have you had any of the following? (check all that apply)

☐ Apprehension about dental treatment
☐ Problems with previous dental treatment
☐ Gag easily
☐ Wear dentures
☐ Food catches between your teeth
☐ Difficulty chewing your food
☐ Chew on only one side of your mouth
☐ Avoid brushing any part of your mouth because of pain
☐ Gums bleed easily
☐ Gums bleed when flossing
☐ Gums feel swollen or tender
☐ Notice slow-healing sores in or around your mouth (cold sores/fever blisters)
☐ Feel twinges of pain when your teeth come into contact with:
  ☐ Hot foods or liquids
  ☐ Cold foods or liquids
  ☐ Sour foods
  ☐ Sweet foods
  ☐ Take fluoride supplements
  ☐ Feel dissatisfied with the appearance of your teeth
  ☐ Want to save your teeth?
  ☐ Want complete dental care?

How often do you brush? ____________________________
How often do you floss? ____________________________

☐ Your jaw makes noise so that it bothers you
☐ Or others
☐ Clench or grind your teeth frequently
☐ Jaws feel tired
☐ Jaw gets stuck so that you can’t open freely
☐ Pain when you chew or open wide to take a bite
☐ Earaches or pain in front of your ears
☐ Jaw symptoms or headaches upon awaking in the morning
☐ Jaw pain or discomfort affecting your appetite, sleep, daily routine, or other activities
☐ Jaw pain or discomfort that is extremely frustrating or depressing
☐ Take medications for pain or discomfort (pain relievers, muscle relaxants, antidepressants)
☐ Temporomandibular (jaw) disorder (TMD)
☐ Pain in the face, cheeks, jaws, joints, throat, or temples
☐ Unable to open your mouth as far as you want
☐ Aware of an uncomfortable bite
☐ Had a blow to the jaw (trauma)
☐ Habitually chew gum?
☐ Smoke Cigarettes? ☐ Pipe? ☐ E-Cigarettes (Vape) ☐ Other? _______________
☐ Use chewing tobacco?