Dental History Age 6 and over

Name______________________________ Today's Date________________

Date of Birth_______________________

Please circle Y or N

Are you presently in any dental pain?	Y	N
Have you ever experienced an unfavorable reaction to dentistry?	Y	N
Have you had your wisdom teeth removed?	Y	N
Have you ever lost or chipped any teeth?	Y	N
Have you had any injuries to face, mouth or teeth?	Y	N
Is any part of your mouth sensitive to temperature or pressure?	Y	N
Do your gums bleed when you brush?	Y	N
Do you have a tongue or thumb habit?	Y	N
Are you a mouth breather?	Y	N
Have you seen an orthodontist?	Y	N
If yes when?_____________________		
Do your teeth or jaws feel uncomfortable when you wake?	Y	N
Are you aware of jaw popping or clicking?	Y	N
Are you aware of clenching your teeth during the day?	Y	N
Have you been told that you grind your teeth?	Y	N
Do you have "tension" headaches?	Y	N
Have you ever experienced chronic ringing in your ears?	Y	N
Do you notice plaque build up on teeth between brushings?	Y	N
Do you take medications that dry your mouth out?	Y	N
Does your mouth feel dry anytime day or night?	Y	N
Do you eat or drink sugary foods between meals? (Soft drinks, juice, energy drinks or coffee with sugar)	Y	N
Have you had a new cavity in the last 24 months?	Y	N
Do you wear dental appliances? (Braces, partials, retainers)	Y	N
Do you use a CPAP machine for Sleep Apnea?	Y	N
If so how often? ______________________		

Do any of these health concerns apply to you? Check all that apply.

Special health care needs	___	Other drug use	___
Frequent tobacco use	___	Bulimia	___
Acid reflux	___	Sjogren's syndrome	___
Diabetes	___	Sleep Apnea	___
Head/neck radiation therapy	___		