DENTAL HISTORY

What is your main concern about your teeth? _____

_____

How often do you have your teeth cleaned? _____

Do you floss? Yes or No How often? _____

What kind of toothbrush do you use? Manual or Electric

Do your gums bleed either in chewing, brushing or at any other time? Yes or No

If yes, please explain: _____

Have your gums ever been treated for gum disease? Yes or No When? _____

Do you have any pain or soreness in your teeth or gums? Yes or No

Does food catch between your teeth? Yes or No If yes, where? _____

Are your teeth sensitive to sweets, temperature, or pressure? Yes or No

Do you notice popping or clicking in your jaw when you open or close? Yes or No

Do you clench or grind your teeth? Yes or No

Upon waking up, are your jaw muscles sore? Yes or No

Have you had orthodontic treatment? Yes or No