PATIENT NAME _____ **DATE**_____ # DENTAL HISTORY

Please check any of the following problems that apply to you.

__ Sensitivity (hot, cold, sweet)
__ Tooth pain or discomfort when chewing
Headaches, earaches, neck pain
__ Jaw joint pain
__ Teeth or fillings breaking
__ Grinding or clenching teeth
__ Bleeding, swollen or irritated gums
__ Loose, tipped or shifting teeth
__ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

_____Dentures
_____Partial dentures
_____Braces
_____Periodontal (gum) treatments

Please share the following dates:

Your last cleaning _____

Your last oral cancer screening _____

Your last complete X-Rays _____

If you **could whiten your teeth for a cost you could afford, would you do it?** _____

Do you smoke or use chewing tobacco?
How much?_____ **For how long?** _____
If you could change your smile, you would :
__ Make them brighter
Make them straighter
__ Close spaces
__ Replace black metal fillings with natural,tooth-colored fillings
__ Repair chipped teeth
__ Replace missing teeth
__ Replace old crowns that don't match
__ Have a smile makeover

On a scale of 1-10, with 10 the highest rating:
How important is your dental health to you?
1 2 3 45 6 7 8 9 10
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10
How important is the appearance of your smile?
1 2 3 4 5 6 7 8 9 10
Where would you rate the appearance of your smile?
1 2 3 4 5 6 7 8 9 10

Sleep History:

1. Have you been told that you snore? YES/NO
2. Do you have daytime drowsiness? ___ YES/NO
3. Have you ever been told that you stop breathing when sleeping? _____ YES/NO
4. Do you wake up feeling refreshed? YES/NO
5. How many hours of sleep per night do you get? ___ HRS
6. Have you ever had a sleep study? YES/NO
7. Have you ever been diagnosed with sleep apnea? YES/NO
8. Are you CPAP intolerant? YES/NO

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Why did you leave your previous dentist? _____

_____

What is the most important thing to you about your future smile and dental health? _____

_____

What is the most important thing to you about your dental visit today? _____

_____

Name of last dentist: _____

City/State/Phone _____