

## DENTAL HISTORY QUESTIONNAIRE

Your most recent Dentist: \_\_\_\_\_ Date of last dental visit: \_\_\_\_\_

Do you have any dental concerns now? \_\_\_\_\_

Do you have or have you ever had: (Please circle all that apply)

- ☐ Orthodontics (braces)
- ☐ A splint or nightguard
- ☐ Periodontal (gum disease)
- ☐ Problems with Novocain
- ☐ Complications with dental procedures?
- ☐ TMJ Problems
- ☐ Painful or bleeding gums
- ☐ Jaw joint noises
- ☐ Nitrous oxide/Laughing gas
- ☐ Problems keeping mouth open

\*Other:

\_\_\_\_ Are you in a field in which your appearance or speech are important? Why:

\_\_\_\_ Have you ever whitened or bleached your teeth?

\_\_\_\_ Are you nervous about dental care?

\_\_\_\_ Do you use breath mints/etc. regularly?

\_\_\_\_ Do you use an automatic toothbrush?

\_\_\_\_ Do you chew gum regularly?

### **Bite/Jaw Concerns:**

\_\_\_\_ A mismatched bite

\_\_\_\_ Is it hard to relax your jaw?

\_\_\_\_ Is your bite uncomfortable?

\_\_\_\_ Your teeth seem chipped or worn down?

\_\_\_\_ Clenching

\_\_\_\_ Grinding

\_\_\_\_ Difficulty breathing through your nose?

\_\_\_\_ Do you bite your tongue or cheeks often?

Other \_\_\_\_\_

### **Trauma History:**

Have you ever been involved in an automobile accident or other trauma (horses, recreational injury, bike, etc?) \_\_\_\_\_

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### **Doctors Notes:**