



Dental history

Name of previous dentist:

Date of last visit:

Are your teeth sensitive to:

Hot or cold?

Sweets?

Biting or chewing?

Have you noticed any mouth odors ?

Do you:

Clench or grind your teeth (day or night)?

Bite your lips or cheeks regularly?

Hold pencils, pipes,pins with your teeth?

Mouth breathe while awake or asleep?

Have tired jaws, especially in the morning?

Snore or have any other sleeping disorders?

Smoke/chew tobacco?

Bite your nails?

Have you ever had:

Orthodontic treatment?

Oral surgery?

Periodontal treatment?

Bite adjusted?

Mouth guard?

A serious injury to mouth or head? if yes, explain

Have you ever experienced:

Clicking or popping of the jaw?

Pain?(joint,ear, side of face)?

Difficulty opening or closing mouth?

Difficulty chewing?

Headaches, neckaches, or shoulder aches?

Sore muscles(neck/ shoulders)?

Food caught between teeth?

Loose teeth or changes in your bite?

Are you satisfied with your teeth's appearance?