# DENTAL HISTORY

(please answer yes or no)

**GUM AND BONE**

Do your gums bleed or are they painful when brushing and flossing?

Have you ever been treated for gum disease or been told you have bone loss around your teeth?

Have you ever noticed an unpleasant order or taste in your mouth?

Is there anyone with periodontal disease in your family?

Have you ever experienced gum recession?

Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?

Have you experienced a burning or painful sensation in your mouth not related to your teeth?

**TOOTH STRUCTURE**

Have you had any cavities within the last 3 years?

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?

Do feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?

Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?

Do you have grooves or notches on your teeth near the gum line?

Have you ever broken teeth, chipped teeth, or had a tooth ache or cracked filling?

Do you frequently get food caught between any teeth?

**BITE AND JAW JOINT**

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)

Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?

Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard dry foods?

In the past 5 years have your teeth changed (become shorter, thinner or worn) or has your bite changed?

Are your teeth becoming more crooked, crowded or overlapped?

Are your teeth developing spaces or becoming loose?

Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?

Do you place your tongue between your teeth or close your teeth against your tongue?

Do you chew ice or bite your nails, use your teeth to hold objects, or have any other oral habits?

Do you clench or grind in the daytime or make them sore?

Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or awareness of your teeth?

Do you wear or have you ever worn an appliance?

**SMILE CHARACTERISTICS**

Is there anything about your teeth you would like to change (shape, color, size)?

Have you ever whitened (bleached) your teeth?

Have you felt uncomfortable or self-conscious about the appearance of your teeth?

Have you been disappointed about the appearance of previous dental work?