DENTAL HISTORY

What brings you in today?:

Previous Dentist:

Have you ever had braces?: __Y (Date:_____________) __N

Have you ever had dental surgery?: __Y __N
Please explain:

Have you ever had trauma to your face or jaw?: __Y __N
Please explain:

Have you ever been treated for gum disease?: __Y __N
How long ago?:

Do you sleep with a CPAP Machine? __Y __N
Do you sleep with an oral appliance? __Y __N

Please check any of the following that apply to you:

- ☐ Difficulty chewing food
- ☐ Pain when eating
- ☐ Swollen or tender gums
- ☐ Bleeding gums
- ☐ Bad breath
- ☐ Mouth breathing
- ☐ Oral Habits (fingernail biting, cheek biting)
- ☐ Frequent headaches
- ☐ Facial pain (nonspecific)
- ☐ Postural problems
- ☐ TMJ pain
- ☐ TMJ noise
- ☐ Limted mouth opening
- ☐ Dry mouth
- ☐ Unpleasant taste
- ☐ Food Impaction
- ☐ Difficulty flossing
- ☐ Broken teeth/fillings
- ☐ Loose teeth
- ☐ Nervousness
- ☐ Ear congestion
- ☐ Vertigo (dizziness)
- ☐ Tinnitus (ringing in ears)
- ☐ Dysphagia (difficulty swallowing)
- ☐ Daytime clenching or grinding
- ☐ Nighttime clenching or grinding
- ☐ Sensitive teeth
- ☐ Burning tongue or mouth
- ☐ Sores or ulcers in mouth
- ☐ Neck Pain

Clinician Only

When was the last time you visited a dentist?

Reason for changing dentists?

How would you rate previous dental experiences?
__Great __Good __Okay __Poor

Please explain:

How often do you brush?

How often do you floss?

Do you drink bottled water? __Y __N

How often? __Daily __Weekly __Occasionally

What are your dental priorities (check all that apply):
__Optimal Oral Health __Esthetics & Cosmetics __Form & Function

NORTHWOODS DENTISTRY