

Dental History

Reason for today's visit _____

Date of last dental visit _____ Date of last dental x-rays _____

Do you have any of the following:

- ☐ Teeth sensitive to cold, heat or sweets
- ☐ Teeth sensitive when chewing
- ☐ Bleeding or swollen gums
- ☐ Loose teeth
- ☐ Food collecting between teeth
- ☐ Broken fillings
- ☐ Grinding or clenching teeth
- ☐ Clicking or popping of the jaw
- ☐ Jaw tiredness
- ☐ Pain around your ear
- ☐ Burning of the tongue
- ☐ Sores or swellings in your mouth
- ☐ Bad breath
- ☐ Complication from extractions
- ☐ Problems during previous dental work
- ☐ Cigarettes, pipe, or cigar smoking
- ☐ Chewing tobacco
- ☐ Dry mouth
- ☐ Blisters on lips or mouth
- ☐ Lip or cheek biting

Do you like your smile? _____

How often do you brush? _____

How often do you floss? _____