HEALTH HISTORY

Have you had any of the following?	Yes	No
Does your jaw “click” or hurt?	☐	☐
Do you feel you grind your teeth?	☐	☐
Have you ever had orthodontic treatment?	☐	☐
Do you wear a dental night guard?	☐	☐
Have you ever had periodontal (gum) treatment?	☐	☐
Have you ever had your bite adjusted?	☐	☐
Do you bite your lips or cheeks often?	☐	☐
Do you smoke?	☐	☐
Do you think you have occasional bad breath?	☐	☐
Do your gums ever bleed when you clean your teeth?	☐	☐
Do you experience sensitivity with hot/cold?	☐	☐
Do your teeth ever hurt when you bite hard?	☐	☐
Does floss ever tear between your teeth?	☐	☐
Does food get jammed between your teeth?	☐	☐
Is there anything else you would like us to know?	☐	☐

_____

How long since your last dental appointment?: _____

How often do you have dental examinations?: _____

Previous dental x-rays were taken: Less than 1 year ☐ Longer than 1 year ☐

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