Water's Edge Dentistry

PATIENT'S DENTAL HISTORY

Name:___________________________Date of Birth:__/__/___

Reason for this visit:
When was your last dental visit:
How often did you visit the dentist before then:
Previous Dentist (Name and Location):
Have you had a complete series of dental films (x-rays) taken when/where:

How often do you brush your teeth? _______ How often do you floss your teeth? _______

Do your gums bleed while brushing or flossing? **Yes No**
Have you ever had periodontal treatment (Gums)? **Yes No**
Do you use an electric toothbrush? **Yes No**
Are your teeth sensitive to hot or cold liquids/foods? **Yes No**
Do you feel pain to any of your teeth? **Yes No**
Do you have any sores or lumps in or near your mouth? **Yes No**
Have you had any head, neck or jaw injuries? **Yes No**
Have you ever experienced any of the following problems in your jaw? **Yes No**
- **Clicking** **Yes No**
- **Pain (joint, ear, side of face)** **Yes No**
- **Difficulty in opening or closing** **Yes No**
- **Difficulty in chewing** **Yes No**

Do you have frequent headaches? **Yes No**
Do you clench or grind your teeth? **Yes No**
Ever worn a nightguard or other appliance? **Yes No**
Do you bite your lips or cheeks frequently? **Yes No**
Have you noticed any loosening of your teeth? **Yes No**
Does food tend to become caught between your teeth? **Yes No**
Have you ever had any difficult extractions in the past? **Yes No**
Have you ever had any prolonged bleeding following extractions? **Yes No**
Do you wear dentures or partials? **Yes No**
Have you ever received oral hygiene instructions regarding the care of your teeth and gums? **Yes No**

If you could change anything about your smile, what would you change?______________________

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Have you ever had a Sleep Study? **Yes No**
Ever you been told you should wear CPAP? **Yes No**
Are you excessively tired during the day? **Yes No**
Do you have a history Hypertension? **Yes No**
Have you been told that you gasp for air or stop breathing while sleeping? **Yes No**
Do you snore? **Yes No**