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? _____