PATIENT DENTAL HISTORY

1. Do your gums bleed while brushing or flossing? ___yes ___no
2. Are your teeth sensitive to hot or cold liquids/foods? ___yes ___no
3. Are your teeth sensitive to sweet or sour liquids/foods? ___yes ___no
4. Do you feel pain to any of your teeth? ___yes ___no
5. Do you have any sores or lumps in or near your mouth? ___yes ___no
6. Have you had any head, neck or jaw injuries? ___yes ___no
7. Have you ever experienced any of the following problems in your jaw?
    a) Clicking? ___yes___no
    b) Pain (joint, ear, side of face)? ___yes ___no
    c) Difficulty in opening or closing? ___yes ___no
    d) Difficulty in chewing? ___yes ___no
8. Do you have frequent headaches ___yes ___no
9. Do you clench or grind your teeth? ___yes ___no
10. Do you bite your lips or cheeks frequently ___yes___no
11. Have you ever had any difficult extractions in the past? ___yes ___no
12. Have you had any orthodontic work? ___yes ___no
13. Have you ever had prolonged bleeding following an extraction? ___yes ___no
14. Have you ever had instruction on correct method of brushing your teeth? ___yes ___no
15. Have you ever had instruction on the care of your gums? ___yes ___no
16. Have you ever had botox or dermalfillers? ___yes ___no
17. Have you ever had periodontal surgery or gum treatment ___yes ___no

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health

SIGNATURE _____ **DATE**_____