Dental History Form (14+ years old)

Patient Name: _____ Today's Date: _____

Please answer the following questions with a **Y**, **N**, **DK**, or **N/A**:

Are your currently experiencing dental pain or discomfort? _____ If yes, where? _____

Do your gums bleed? _____

Are your teeth sensitive to:
Hot? _____ Cold? _____ Sweets? _____ Pressure? _____

Is your mouth dry? _____

Have you ever had a periodontal treatment (aka deep cleaning)? _____

Have you ever had orthodontic treatment? _____
Do your wear retainers? _____

Do you wear a nightguard? _____

Do you have: Earaches? _____ Neck pain? _____ Headaches? _____

Do you have: Jaw clicking/popping? _____ Jaw/facial discomfort? _____

Do you:
Grind/clench your teeth? _____
Snore? _____
Have Sleep Apnea? _____
Use a CPAP? _____
Have trouble breathing through your nose? _____

Do you wear dentures? _____ Partials? _____

Do you participate in recreational activities (basketball, soccer, tennis, golf, etc)? _____
Do you wear a sports mouthguard? _____

Have you had a serious injury to your head or mouth? _____

SMILE SURVEY

- Are you happy with the appearance of your teeth, gums, and smile? **YES NO**
    - Now that you mention it…can we talk about _____?

- Would you like to discuss if you are a good candidate for teeth whitening? **YES NO**