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Welcome! So that we may provide you with the best possible care, please print and complete this dental history form. All information will be kept completely confidential.

How often do you brush your teeth?_____ Floss?_____
What other dental aids do you use? (Interplak, toothpick, etc.)_____
Do you have dental problems now? If so, please describe_____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad taste?	Yes	No
Do you frequently get cold sores?	Yes	No
Blisters or lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where?_____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pins, fingernails, toothpicks)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorder?	Yes	No
If yes, please complete Sleep Disorder Questionnaire at the end of this dental history.		
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to your mouth or head?	Yes	No

If yes, please describe, including cause

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain (joint, ear, side of face)	Yes	No
Difficulty in opening or closing of the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Head, neck or shoulder aches?	Yes	No
Sore muscles? (neck, shoulders)	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?_____

Have you ever had an upsetting dental experience Yes No

If yes, please describe_____

Is there anything else about having dental treatment that you would like us to know? If yes, please describe _____

Sleep Disorder Questionnaire

Y	N	I have recently gained weight.
Y	N	I was told I have high blood pressure.
Y	N	I use high blood pressure medication.
Y	N	I use sleep medications.
Y	N	I use oxygen/CPAP at night.
Y	N	I use medications to help me breath.
Y	N	I have a regular sleep/wake pattern.
Y	N	I fall asleep when driving.
Y	N	My snoring disturbs other people.
Y	N	I have been told that I "stop breathing" when sleeping.
Y	N	I wake up "gasping" or "short of breath".
Y	N	I wake up in the morning with headaches.

The following questions are designed to identify a sleep problem. Choose the most appropriate number for each situation. In contrast to feeling tired, are you likely to doze or fall asleep in the following situations:

0 = Never 1 = Slight chance 2 = Moderate chance 3 = Regularly

___ Sitting and reading
___ Watching television
___ Sitting inactive in a public place (i.e. theater)
___ Passenger in a car for an hour without a break
___ Lying down to rest in the afternoon
___ Sitting and talking to someone
___ Sitting quietly after lunch without alcohol
___ In a car while stopped for a few minutes in traffic