

14995 Shady Grove Rd, Suite 450 Rockville, MD 20850 (301)963-0800



## **Dental History**

Hot / Cold / Sweets? Yes No Oral surgery Yes No No Oral surgery Yes No Oral surgery Ye	Patient Name:					
Date of last dental visit Last dental cleaning Last Full Mouth X-Rays  What was done at your last dental visit?  Previous Dentist's Name Telephone  How often do you have dental examinations?  How often do you brush your teeth?  What other cleaning aids do you use? (waterpik,toothpick,etc.)  Do you have any dental problems now? Yes No  If yes, please describe:  Are any of your teeth sensitive to Hot / Cold / Sweets? Yes No Do you freeth get old sores, Do you frequently get cold sores, Disters or any other oral lesions? Yes No Do your gums bleed or hurt? Yes No Datayse you noticed any loose teeth or change in your bite? Yes No Does food tend to become caught in between your teeth? Yes No Do you: Diff yes, where?  Do your lips or cheeks regularly Yes No Head, neck or shoulder pain Yes No Head with your teeth (pencils, pins, nails, fingernails) Yes No Mouth breathe awake/asleep Yes No Mouth breathe awake/asleep Yes No Sonce or have sleeping disorders Yes No Sonce or have sleeping dental treatment that you would like us to know? Yes No Sons the there anything else about having dental treatment that you would like us to know?  Have you exer had:  How often do you floss?  Have you ever had:  Have you ever had: Have you ever had: Have you ever had: Have you ever had: Have you ever had: Have you ever had: Have you ever had: Have you ever had: Have you ever had: Have you ever had: Have you ever had: Have you ever had: Have you experienced: If (sching or popping of the jaw Yes No No Have you experienced: If (sching or popping or the jaw Yes No No Have you experienced: If (sching or popping or	What is the reason for your visit today?	?				
What was done at your last dental visit?						
How often do you have dental examinations?  How often do you brush your teeth?  What other cleaning aids do you use? (waterpik,toothpick,etc.)  Do you have any dental problems now? Yes No  If yes, please describe:  Are any of your teeth sensitive to Hot / Cold / Sweets?						
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Are any of your teeth sensitive to Hot / Cold / Sweets?						
Hot / Cold / Sweets? Yes No Oral surgery Yes No No Oral surgery Yes No Oral surgery Ye	If yes, please describe:					
Have you noticed any mouth odors or bad tastes? Yes No Oral surgery Yes No Do you frequently get cold sores, Periodontal treatment Yes No blisters or any other oral lesions? Yes No Your teeth ground or bite adjusted Yes No Night Guard Yes No Night Guard Yes No Night Guard Yes No No A serious injury to the mouth, head 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 Difficulty opening or the jaw Yes No Difficulty opening or closing mouth Yes No Difficult	Are any of your teeth sensitive to					
or bad tastes? Yes No Oral surgery Yes No Do you frequently get cold sores, Periodontal treatment Yes No Do you frequently get cold sores, Periodontal treatment Yes No 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 Do you:  Clench or grind your teeth while awake or asleep Yes No Bite your lips or cheeks regularly Yes No Bite your lips or cheeks regularly Yes No Sore muscles (neck, shoulder pain Yes No Have tired jaws, especially in the Morning Yes No Somoke/chew tobacco products Yes No Somoke/chew tobacco products Yes No Do you feel nervous about dental treatment? Yes No Sore musthing else about having dental treatment that you would like us to know? Yes No Your teeth whole In the Norman Yes No	Hot / Cold / Sweets?	Yes	No	Have you ever had:		
Periodontal treatment Yes No Night Guard Yes No	Have you noticed any mouth odors			Orthodontic treatment	Yes	No
No Night Guard	or bad tastes?	Yes	No	Oral surgery	Yes	No
Night Guard	Do you frequently get cold sores,			Periodontal treatment	Yes	No
Do your gums bleed or hurt? Yes No If yes, please describe	blisters or any other oral lesions?	Yes	No	Your teeth ground or bite adjusted	Yes	No
Have you noticed any loose teeth or Change in your bite?				-	Yes	No
change in your bite? Yes No Does food tend to become caught In between your teeth? Yes No Have you experienced:  Clicking or popping of the jaw Yes No Pain (joint, ear, side of face) Yes No Do you:  Clench or grind your teeth while Bawake or asleep Yes No Bite your lips or cheeks regularly Yes No Bolite your lips or cheeks regularly Yes No Hold objects with your teeth (pencils, pins, nails, fingernails) Yes No Have tired jaws, especially in the Morning Yes No Sone muscles (neck, shoulders) Yes No Have tired jaws, especially in the Morning Yes No Sone or have sleeping disorders Yes No Sone or have		Yes	No			No
In between your teeth?	change in your bite?	Yes	No			
Clicking or popping of the jaw Yes No Pain (joint, ear, side of face) Yes No Difficulty opening or closing mouth Yes No Difficulty opening or closing mouth Yes No Difficulty chewing on either side Yes No Bite your lips or cheeks regularly Yes No Sore muscles (neck, shoulder pain Yes No Hold objects with your teeth (pencils, pins, nails, fingernails) Yes No Are you satisfied with your teeth's appearance? Mouth breathe awake/asleep Yes No Have tired jaws, especially in the Morning Yes No Sone or have sleeping disorders Yes No Sone or	• .					
Pain (joint, ear, side of face)	n between your teeth?	Yes	No	Have you experienced:		
Do you:  Clench or grind your teeth while wake or asleep	f yes, where?			Clicking or popping of the jaw	Yes	No
Clench or grind your teeth while  awake or asleep				Pain (joint, ear, side of face)	Yes	No
Awake or asleep	Do you:			Difficulty opening or closing mouth	Yes	No
Bite your lips or cheeks regularly Yes No Sore muscles (neck, shoulders) Yes No Hold objects with your teeth (pencils, pins, nails, fingernails) Yes No Mouth breathe awake/asleep Yes No Have tired jaws, especially in the Morning Yes No Shore or have sleeping disorders Yes No Shore or have sleeping disorders Yes No Shore anything else about having dental treatment that you would like us to know? Yes No	Clench or grind your teeth while			Difficulty chewing on either side	Yes	No
Hold objects with your teeth  (pencils, pins, nails, fingernails) Yes No Are you satisfied with your teeth's appearance?  Mouth breathe awake/asleep Yes No Yes No  Have tired jaws, especially in the If so, what is your biggest concern?  Morning Yes No  Smore or have sleeping disorders Yes No  Smoke/chew tobacco products Yes No  Do you feel nervous about dental treatment?  Yes No  State anything else about having dental treatment that you would like us to know?  Yes No	awake or asleep	Yes	No	Head, neck or shoulder pain	Yes	No
Are you satisfied with your teeth's appearance?  Mouth breathe awake/asleep Yes No Have tired jaws, especially in the Morning Yes No Snore or have sleeping disorders Yes No Smoke/chew tobacco products Yes No Smoke/chew tobacco products Yes No State anything else about having dental treatment that you would like us to know?  Yes No  Yes No  Do you feel nervous about dental treatment?  Yes No		Yes	No	Sore muscles (neck, shoulders)	Yes	No
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Smore or have sleeping disorders Yes No  Smoke/chew tobacco products Yes No  Do you feel nervous about dental treatment?  Yes No  s there anything else about having dental treatment that you would like us to know?  Yes No	· · · · · · · · · · · · · · · · · · ·	res	INO	If so, what is your biggest concern?		INO
Smoke/chew tobacco products Yes No Do you feel nervous about dental treatment?  Yes No  Is there anything else about having dental treatment that you would like us to know?  Yes No	Morning	Yes	No			
Yes No Is there anything else about having dental treatment that you would like us to know?  Yes No	• -	Yes	No			
Is there anything else about having dental treatment that you would like us to know? Yes No	Smoke/chew tobacco products	Yes	No	Do you feel nervous about dental treat		
					Yes	No
	Is there anything else about having der If yes, please describe	ntal trea	tment that you	would like us to know?	Yes	No