ALBA DENTAL CENTRE

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DENTAL HISTORY

	YES	Don't Know/ MAYBE	NO
Do you? • Grind or clench your teeth during the day or night? ______	☐	☐	☐
• Mouth breathe while awake or asleep? ______	☐	☐	☐
• Bite your lips or cheeks regularly? ______	☐	☐	☐
• Hold any foreign objects with your teeth? (i.e. pipe, pencils, nails) ______	☐	☐	☐
• Chew bubble gum and how often? ______	☐	☐	☐
• Have any history of trauma? ______	☐	☐	☐
• Does your jaw crack or pop when opened widely? ______	☐	☐	☐
• Have any difficulties in opening or closing your jaw? ______	☐	☐	☐
• Have you ever had any of the following: ☐ Oral surgery ☐ Gum surgery ☐ Braces ☐ Other appliances?	☐	☐	☐
• Is your sugar intake: ☐ High ☐ Medium ☐ Low?	☐	☐	☐
• Has your bed partner ever mentioned any snoring habit? ______	☐	☐	☐
• Wake up with headache, or tired? ______	☐	☐	☐
• Smoke? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Other ______ No. per day ______			

Check any of the following you are interested in or you have thought about:

- ☐ Orthodontics (braces or Invisalign)
- ☐ Bonding (straightening)
- ☐ Closing spaces between teeth
- ☐ Replacing missing teeth
- ☐ Repairing chipped teeth
- ☐ Bleaching (whitening teeth)
- ☐ Crowns (caps)
- ☐ Sports mouth guard
- ☐ Improved gum health
- ☐ Improving your bite
- ☐ Improving breath odor
- ☐ Improving your smile
- ☐ Wisdom teeth extraction
- ☐ Sleep apnea and snoring
- ☐ Dental treatment under sedation
- ☐ Dentures

Would you rate your current dental health as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any emotional concerns regarding your dental visit? ☐ Fear ☐ Pain ☐ Time Money ☐ Embarrassment

	YES	NO
Other concerns: ______	☐	☐
Have you ever been advised to take antibiotics before dental appointments? ______	☐	☐
Do your gums bleed when you brush? ______	☐	☐
Do you have any pain when you chew? ______	☐	☐
Do you feel that you have bad breath? ______	☐	☐
Have you ever been in a motor vehicle accident or experienced any force/impact to your jaw? ______	☐	☐
Have you ever had dental implant surgery? ______	☐	☐
If yes, who performed the surgery and when was it done? ______	☐	☐

Are you being followed-up by a dental specialist? ______

Please list anything else not mentioned above regarding your past dental history: ______

______

Comments: ______

______

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