The Hub Dental Practice

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DENTAL HEALTH HISTORY

Please describe your Current Dental Problem (Describe the signs and symptoms; how long it has been going on; what attempts have been made to sort out the problem by yourself, your doctor or dentist)

We want to meet Your Expectations. So please indicate what would be a favourable outcome to your presenting problem. (An example might be "Extracting my tooth", "Recementing my crown", "Filling the hole in my tooth", "Stopping the pain".) The more information you give us the easier it will be to meet your expectations.

If this is your first visit then please give name/location of previous dentist _____
If this is your first visit then please date of your last dental appointment (approx is OK) _____
How often do you brush? _____
How often do you floss? _____
Does your jaw make noise so that it bothers you or others? _____
Do you clench or grind your jaws frequently? _____
Do your jaws ever feel tired? _____
Does your jaw get stuck so that you can't open freely? _____
Does it hurt when you chew or open wide to take a bite? _____
Do you have earaches or pain in front of the ears? _____
Do you have any jaw symptoms or headaches upon awaking in the morning? _____
Does jaw pain or discomfort affect your sleep, daily routine, or other activities? _____
Does jaw pain or discomfort affect your appetite? _____
Do you find jaw pain or discomfort extremely frustrating or depressing? _____
Do you have a temporomandibular (jaw) disorder (TMD)? _____
Do you have pain in the face, cheeks, jaws, joints, throat, or temples? _____
Are you unable to open your mouth as far as you want? _____
Are you aware of an uncomfortable bite? _____
Have you had a blow to the jaw (trauma)? _____
Are you a habitual gum chewer or pipe smoker? _____

	Yes or No		Yes or No
Do you gag easily?	____	Do you wear dentures?	____
Does food catch between your teeth?	____	Do you have difficulty in chewing your food?	____
Do you chew on only one side of your mouth?	____	Are you apprehensive about dental treatment?	____
Do your gums bleed easily?	____	Do your gums bleed when you floss?	____
Do your gums feel swollen or tender?	____	Are your teeth sensitive?	____
Do you prefer to save your teeth?	____	Do you want complete dental care?	____

Yes or No

Have you had problems with previous dental treatment? ____
Have you ever had dental treatment from an oral surgeon? ____
Have you ever had dental treatment from a specialist dentist? ____
Have you ever had dental treatment in or requiring a visit to or stay in a hospital? ____
Do you avoid brushing any part of your mouth because of pain? ____
Have you ever noticed slow-healing sores in or about your mouth? ____
Are you dissatisfied with the appearance of your teeth? ____

Do you feel twinges of pain when your teeth come in contact with:

Hot foods or liquids?	____	Cold foods or liquids?	____
Sour foods or liquids?	____	Sweet foods or liquids?	____

Have you ever thought about having:

Cosmetic treatment?	____	Botox or facial fillers?	____	Orthodontics?	____
Implants?	____	Sedation?	____	A smile Make Over?	____

Please add any comments below you would like to add (things we missed or that are important to you or maybe personal/social information which is **relevant** to your Dental Health.)