V. Dental History

1. **Do you like your smile?**_____

   If not, what would you change? _____

   _____

2. Yes No Do you have any dental complaints or concerns at this time?
   Please explain _____

3. Yes No Have you ever had orthodontic treatment (braces)?
4. Yes No Do your jaws click when you chew or are your chewing muscles sore?
5. Yes No Do you clench your teeth during the day or night?
6. Yes No Do you have a finger, thumb, pencil, or a nail chewing habit?
7. Yes No Do you have any sensitivity to sweets, hot, cold or biting pressure?
8. Yes No Have you noticed any growths or sore spots around your mouth?
9. Yes No Do your gums bleed when you brush?
10. Yes No Have you been treated for gum or periodontal disease?
11. Yes No Do you feel that you have a problem with cavities?
12. Yes No Do you use fluoride toothpaste?
13. Yes No Do you use mouthwash daily? What type? _____
14. Yes No Do you chew gum daily?
15. Yes No Do you regularly use throat lozenges, cough drops, mints, tums, breath fresheners, etc.?
16. Yes No Do you drink soda pop? How much? _____
17. Yes No Have you had any difficult extractions or any prolonged bleeding following an extraction?
18. Yes No Have you ever had a severe reaction to dental treatment? If so, please describe the reaction:

    _____
19. Yes No Have you experienced an unusual reaction to dental anesthesia or nitrous oxide (gas)?
20. Yes No Have you had instruction on the correct method to brush your teeth and care for your gums?
21. How often do you brush your teeth?_____ How often do you floss?_____
22. When did you visit a dentist last? _____ Dentist's name _____
22. When were your last x-rays taken? _____ How many were taken?_____

I concur that the above dental history is correct and complete

Parent/Patient Signature_____