DENTAL HISTORY

	Yes	No
Have you had orthodontic treatment? If yes. when? _____	_____	_____
Do you have un-replaced missing teeth?	_____	_____
Do your gums bleed when brushing your teeth?	_____	_____
Is any part of your mouth sensitive to temperature or pressure? If yes. what part? _____	_____	_____
Do you have any unpleasant odor or taste in your mouth?	_____	_____
Does food catch between your teeth? If yes. where? _____	_____	_____
Are you dissatisfied with your teeth and their appearance?	_____	_____
Do you clench or grind your teeth during the day?	_____	_____
Have you been made aware of clenching / grinding your teeth during the night?	_____	_____
Do you have chronic headaches or neck and shoulder pains?	_____	_____
Do you have headaches when you wake up?	_____	_____
Do you ever wake up with awareness of or about your teeth or jaw like you've had them clenched in your sleep?	_____	_____
Do you have any awareness of discomfort in the muscles of your neck or shoulders	_____	_____
Has your jaw ever locked?	_____	_____
Do you now or have you ever had pain in your jaw joint or the sides of your face (in and about the ears)?	_____	_____
Have you been diagnosed as having migraine headaches?	_____	_____
Do you have a clicking jaw joint or have you ever experience and inability to move your jaw or open your mouth wide?	_____	_____
Which side do you chew on? Right _____ Left _____ Both _____		
Have you ever had a bite splint or night guard?	_____	_____
If yes do you wear one now?	_____	_____
Do you have any dental complaints not specifically covered above?	_____	_____

When were your last dental X-rays taken? _____

If you think we might be able to obtain them please list the dentist's name and telephone number here: _____