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Please Circle An Answer For Each Behavior /Habits Question

Do You Have Pain In Your Jaw Joints? Left / Right / Both With Opening / Closing
Do Your Jaw Joints Ever Pop / Click? Left / Right / Both With Opening / Closing
Do you have history of trauma to the jaw? Yes / No If yes, explain _____

Grind your teeth:	Present / Past / Never	Bite your Nails:	Present / Past / Never
Bite you cheek:	Present / Past / Never	Thumb / Finger sucker:	Present / Past / Never
Tongue thruster:	Present / Past / Never	Toothpick / Stimulator:	Present / Past / Never
Mouth breather:	Present / Past / Never	Chew gum:	Present / Past / Never
Bulimia/Anorexia:	Present / Past / Never	Eat Candy:	Present / Past / Never
Use Cigar/Cigarette:	Present / Past / Never	How much?	_____
Use a Pipe:	Present / Past / Never	Drink Soda:	Present / Past / Never
Use Smokeless Tobacco:	Present / Past / Never	How much?	_____

Other: _____ Description: _____
Comments: _____

Please Indicate An Answer For Each General Question

How often do you Brush? _____ Type of toothpaste: _____
How often do you Floss? _____ Do You Use Mouthwash? Yes / No

Please Circle An Answer For Each Question

Are Your Teeth Sensitive To:				Comments
Hot and/or Cold?	Present	Past	Never	_____
Biting / Chewing?	Present	Past	Never	_____
Sweets?	Present	Past	Never	_____
Have You Ever Had:				
Orthodontia / Braces?	Present	Past	Never	_____
Worn a Night Guard?	Present	Past	Never	_____
Oral Surgery / Teeth removed?		Past	Never	_____
Have a serious injury to the mouth / head?		Past	Never	_____

What type of toothbrush do you use? Regular / Electric / Sonic
Do your gums bleed with Brushing or Flossing? Brushing / Flossing / Both

Have you ever been diagnosed with Periodontal (Gum) disease? Yes / No If yes, when _____
Have you had any Periodontal surgery or Deep Cleaning of the teeth? Yes / No If yes, when _____

Who was your previous dentist? _____ City _____
Date you were last seen in that office? _____ Do we need to request any current x-rays? Yes / No

Do you want to add any additional comments?
_____
_____
Patient Name: _____