**Dental Health Information**

Reason for your visit to our office:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental visit:\_\_\_\_/\_\_\_/\_\_\_ Date of last dental cleaning:\_\_\_/\_\_\_/\_\_\_

 **Yes**  **No**

Are you in pain? .................................................................. \_\_\_\_ \_\_\_\_

Are you under unusual stress at home/work? .................... \_\_\_\_ \_\_\_\_

Have you had temporomandibular joint (TMJ) problems before? ………… \_\_\_\_ \_\_\_\_

Do you clench or grind your teeth? .............................. \_\_\_\_ \_\_\_\_

Do your gums feel tender or swollen? ……………….. \_\_\_\_ \_\_\_\_

Do your gums bleed while brushing or flossing? (circle one or both) ……… \_\_\_\_ \_\_\_\_

Do you gag easily? ……………………………………………… \_\_\_\_ \_\_\_\_

Do you have an electric tooth brush?.............................................. \_\_\_\_ \_\_\_\_

Have you ever been given Nitrous Oxide (laughing gas)? \_\_\_\_ \_\_\_\_

 Do you like Nitrous Oxide? \_\_\_\_ \_\_\_\_

Are our teeth sensitive to: (Circle all that apply) Cold Hot Sweet Sour

Do you wear dentures upper/lower or partials upper/lower? (circle all that apply)

How often do you brush your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of toothpaste do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Texture of toothbrush you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_