Susan G. Gross DDS

Smiles For Life

Dental and Oral Health History

Name: _____

Reason for your visit today: _____

When did you last visit a dentist? _____

Are you aware of any dental problems? _____

Do you have any sore spots in your mouth? _____

Have you ever had any of the following?

Gum Disease/Periodontal Therapy: _____

Oral Surgery/Dental Implants/Extractions: _____

Orthodontic treatment/Braces: _____

Dental Appliances i.e. Night Guard, Apnea/Snoring Appliance, Retainers, Dentures, sports mouth guard:

_____

Do you currently or have a history of clenching or grinding your teeth?

_____

Do you experience headaches? _____

Frequency: _____ A.M. or P.M.: _____

Are you aware of or do you have a history of pain, clicking, popping or noises when opening or closing your mouth? _____

Has your jaw ever locked open or closed? _____

Do your gums ever bleed? _____

Does food get caught between your teeth? _____

Are any of your teeth sensitive to sweets, cold, heat or pressure? _____

Have you ever experienced any trauma or injury to your head, jaw or teeth?

_____

Do you experience dryness in your mouth? _____

List all products that you use for maintaining your oral health. Include over the counter and prescription items such as mouth rinses, fluoride supplements, toothpastes and how often you use them.

_____

_____

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Dental and Oral Health History Cont.

List all types of devices you use of removing plaque from the surfaces of your teeth and tongue such as brushes, floss, toothpicks, WaterPik and how often you use them.

_____

_____

List all foods and beverages you consume that have sugar and starch and the frequency they are consumed. Include juice, carbonated and non-carbonated soft drinks, sugar free drinks, energy drinks, candy, mints, gum, cough drops, etc..

_____

_____

Please list any family history of dental/oral disease such as tooth loss, gum disease, frequent cavities or oral cancer.

_____

_____

Do you snore or have difficulty breathing when you sleep?

_____

Do you have difficulty staying awake during the day while at your desk, watching T.V. or while driving in slow moving traffic?

_____

If you had the opportunity to change your teeth in any way what would it be?

_____

_____

Would you like information regarding the connection between your general health and oral health, effect of medications on your oral health, improving your bite, cosmetic improvements to your smile, whitening, sealants, decay prevention procedures, orthodontics, dental implants to replace missing teeth or stabilize dentures, or other topics?

_____

_____

_____

Signature: _____ Date: _____

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