DENTAL HEALTH HISTORY

SOUTHWEST DENTISTRY

Patient Name _____ Date _____

Alcohol Use:	☐ Never	☐ Occasionally	☐ Monthly	☐ Weekly	☐ Daily	☐ 4+ Per Day
Smoking:	☐ Never	☐ Occasionally	☐ 1 Per Day	☐ 1 Pack Per Day	☐ 2+ Packs Per Day	
Illegal Drug Use:	☐ Never	☐ Occasionally	☐ Monthly	☐ Weekly	☐ Daily	
Exercise:	☐ Never	☐ Occasionally	☐ Weekly	☐ 2-3 Times Per Week	☐ Daily	

Dental Symptoms - Please mark any and all that apply:

Pain In Teeth	Y ☐ N ☐	Teeth Sensitivity	Y ☐ N ☐
Teeth Sensitivity to Heat	Y ☐ N ☐	Teeth Sensitivity to Cold	Y ☐ N ☐
Teeth Sensitivity to Sour	Y ☐ N ☐	Teeth Sensitivity to Sweet	Y ☐ N ☐
Bleeding Gums	Y ☐ N ☐	Bleeding Gums after Flossing	Y ☐ N ☐
Sensitive Gums	Y ☐ N ☐	Swollen Gums	Y ☐ N ☐
Headaches	Y ☐ N ☐	Earaches	Y ☐ N ☐
Jaw Aching	Y ☐ N ☐	Tired Jaw	Y ☐ N ☐
Clicking Jaw	Y ☐ N ☐	Jaw Gets Stuck	Y ☐ N ☐
Unable to Totally Open	Y ☐ N ☐	TMJ	Y ☐ N ☐
Clenched Jaw	Y ☐ N ☐	Grinding Teeth	Y ☐ N ☐
Food Catches In Teeth	Y ☐ N ☐	Tongue Pain	Y ☐ N ☐
I Chew Gum Regularly	Y ☐ N ☐		

Dental History - Please mark any and fill out all that apply:

I Brush _____ times per day

I Floss _____ times per day

I Gag Easily	Y ☐ N ☐	Dentist's Make Me Nervous	Y ☐ N ☐
I Chew Tobacco Regularly	Y ☐ N ☐	I Use Vaping Products	Y ☐ N ☐
I Take Pain Relievers Often	Y ☐ N ☐	I Take Muscle Relaxants Often	Y ☐ N ☐
I Take Antidepressants Often	Y ☐ N ☐	I Have Had Trauma To The Head	Y ☐ N ☐
I Have Had Trauma To The Face	Y ☐ N ☐	I Have Had Trauma To The Ear	Y ☐ N ☐
I Have Had Trauma To The Mouth	Y ☐ N ☐	I Have Had Trauma To The Throat	Y ☐ N ☐
I Take Fluoride Supplements	Y ☐ N ☐	I Am Dissatisfied With My Teeth	Y ☐ N ☐
I Wear Dentures	Y ☐ N ☐	I Have Braces	Y ☐ N ☐
I Don't Like The Color of My Teeth	Y ☐ N ☐	I Use a Cpap / Dental Devices	Y ☐ N ☐