PATIENT INFORMATION

CONVERGENT DENTISTRY

DENTAL HEALTH HISTORY

Please Check if you have/had:	Yes	No
Bad breath	☐	☐
Blisters on lips or mouth	☐	☐
Burning sensation on tongue	☐	☐
Chew on only one side of your mouth	☐	☐
Cigarette, pipe or cigar smoking	☐	☐
Smokeless tobacco	☐	☐
Dry mouth	☐	☐
Food collecting between teeth	☐	☐
Clench or grind teeth	☐	☐
Growths or sore spots in your mouth	☐	☐
Gums—swollen, tender or bleeding	☐	☐
Head, neck, jaw pain, or aches	☐	☐
Lip or cheek biting	☐	☐
Loose teeth or broken fillings	☐	☐
Mouth breathing	☐	☐
Nitrous Oxide	☐	☐
Orthodontic previous treatment	☐	☐
Periodontal previous treatment	☐	☐
Sensitivity when your teeth come in contact with:		
Hot foods or liquids	☐	☐
Cold foods or liquids	☐	☐
Sours	☐	☐
Sweets	☐	☐
Pressure	☐	☐

Are you allergic, or have you reacted adversely, to any of the following?	Yes	No
Local anesthetics (“Novocaine”)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofens	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other	☐	☐

	Yes	No
How often do you brush? _____		
How often do you floss? _____		
Do you have a temporomandibular (TMJ jaw) disorder?	☐	☐
Does you jaw make noise so that it bothers you or others?	☐	☐
Does your jaw ever feel tired?	☐	☐
Does you jaw get stuck so that you can not open it freely?	☐	☐
Does it hurt when you chew or open wide take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you have pain in the face, cheeks, jaw, joints throat or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw trauma?	☐	☐
Are you a habitual gum chewer?	☐	☐
Do you take medications (see medication & OTC listing on pg. 2)	☐	☐
Do you take fluoride supplements?	☐	☐
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐
Do you drink alcohol? If so, how much per week _____	☐	☐