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DENTAL HISTORY

Y	N	Teeth sensitive to hot or cold	Y	N	Chipped/injured permanent teeth
Y	N	Previous root canal therapy	Y	N	History of missing or extra teeth
Y	N	Jaw fractures, cysts or infections	Y	N	Any permanent teeth removed
Y	N	Bleeding gums/bad taste/odor	Y	N	Wisdom teeth removed
Y	N	Other periodontal (gum) problems	Y	N	Numerous fillings
Y	N	Food gets trapped in between teeth	Y	N	Teeth that irritate tongue, cheek, lips
Y	N	Frequent canker sores or cold sores	Y	N	Damaged restorations/fillings
Y	N	Mouth breathing/snoring	Y	N	Loose or shifting teeth
Y	N	Thumb/finger sucking habit as a child	Y	N	Abnormal swallowing (tongue thrust)
Y	N	Negative dental experiences	Y	N	Previous orthodontics/retainers
Y	N	Previous periodontal (gum) treatment	Y	N	All dental work completed at this time
Y	N	Diet high in sweets/sugars			

TMJ HISTORY

Y	N	Has the patient had a TMJ screening?
Y	N	Does the patient have pain in his/her jaw joint?
Y	N	Does the patient have a history of jaw joint problems?
Y	N	Does the patient experience soreness in the muscles of his/her face or around ears?
Y	N	Has the patient been treated for TMJ?
Y	N	Does the patient grind his/her teeth?
Y	N	Does the patient notice clicking or popping in his/her jaw joint?
Y	N	Has the patient's jaw ever locked?
Y	N	Does the patient have difficulty chewing or opening his/her mouth?
Y	N	Does his/her bite feel uncomfortable/unusual?

I certify that I have read and understand the above. I acknowledge that I have completed this form to my best knowledge, and that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there are any changes later to the history record or medical or dental status, I will inform the practice.

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Signature of Parent/Guardian Date