



Dr. Anthea McCormick, DMD | 2704 N Halsted St. Chicago, IL 60614 | 773-348-2704

## Dental History

Reason for today's visit \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last dental x-ray \_\_\_\_\_

How often do you brush? \_\_\_\_\_ When do you floss? \_\_\_\_\_

Check if you have had any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Cold Sores or Fever Blisters | <input type="checkbox"/> Jaw Pain                    | <input type="checkbox"/> Braces/Orthodontic Treatment |
| <input type="checkbox"/> Sensitive or Painful Teeth   | <input type="checkbox"/> Clicking/Popping Jaw        | <input type="checkbox"/> Loose Fillings               |
| <input type="checkbox"/> Bad Breath (Halitosis)       | <input type="checkbox"/> Grinding of Teeth (Bruxism) | <input type="checkbox"/> Broken Teeth/Fillings        |
| <input type="checkbox"/> Dry Mouth (Xerostomia)       | <input type="checkbox"/> Clenching of Teeth          | <input type="checkbox"/> Pain upon chewing/biting     |
| <input type="checkbox"/> Bleed Gums                   | <input type="checkbox"/> Pain in or about your ears  | <input type="checkbox"/> Sensitivity to sweets        |
| <input type="checkbox"/> Gum Surgery                  | <input type="checkbox"/> Frequent Headaches          | <input type="checkbox"/> Food packs between teeth     |
| <input type="checkbox"/> "Deep Cleaning"              | <input type="checkbox"/> Migraines                   | <input type="checkbox"/> Dental Implants              |
| <input type="checkbox"/> Periodontal Treatment        | <input type="checkbox"/> Neck-aches                  | <input type="checkbox"/> Wisdom Teeth Extraction      |

- Do you snore? \_\_\_\_\_
- Are you apprehensive or nervous about dental treatment? \_\_\_\_\_
- Would you be interested in sedation or "sleep" dentistry? \_\_\_\_\_
- Do you feel you have a healthy mouth? \_\_\_\_\_
- Do you like your smile? \_\_\_\_\_
- Would you like whiter teeth? \_\_\_\_\_
- Would you like straighter teeth? \_\_\_\_\_
- Do you avoid certain foods due to missing teeth or pain upon chewing?  
\_\_\_\_\_
- If you have missing teeth, would you like them replaced?  
\_\_\_\_\_
- What did you like most about previous dental experiences?  
\_\_\_\_\_
- Why did you leave your previous dentist?  
\_\_\_\_\_
- Is there anything we can do to make your visits more comfortable?  
\_\_\_\_\_