Morfas Family Dentistry
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Dental History

1. When was your last dental check-up? _____
2. Are you having any specific problems with your teeth, gums or mouth? Yes No

   Explain: _____
3. Are your teeth sensitive to hot, cold, or sweets? Yes No
4. Do your gums bleed after brushing; are they often sore or tender? Yes No
5. Have you ever been told you have gum/Periodontal disease? Yes No
6. Do you have fever blisters, mouth ulcers or sores on your lips or mouth? Yes No
7. Do you have chapped lips, cracked or raw places on the corners or mouth? Yes No
8. Do you have difficulty swallowing or chewing? Yes No
9. Do you frequently have food wedged between your teeth? Yes No
10. Have you worn braces for straightening your teeth? Yes No
11. Do you chew tobacco or smoke in any form? Yes No
12. Are you dissatisfied with the appearance of your teeth? Yes No
13. Is there anything about your smile that you would like to change? _____
14. Do you clench or grind your teeth to your knowledge? Yes No
15. Do you notice popping, clicking or soreness of the jaws? Yes No
16. Do you wear dentures or partials? If yes, date of placement: _____
17. Do you use an electric toothbrush? Yes No

Thank you for being a patient at Morfas Family Dentistry and as always, we appreciate your kind referrals to our office.