Supplemental Health Questionnaire

Name________________________________

Have there been any changes in your medical history since your last visit? Yes _____ No _____
(Please refer to previous visit's health history.)

Do you knowingly grind your teeth at night or have been told by a dentist that you may be grinding?
If yes, do you wear a night guard? Yes _____ No _____

Have you ever had a problem with your TMJ /TMD jaw joint? Yes _____ No _____

Has anyone ever commented or told you that you snore? Yes _____ No _____
If yes, how often: rarely _____ sometimes _____ often _____ most nights _____

Has anyone ever heard you stop breathing or choking at night? Yes _____ No _____

How would you rank your quality of sleep on most nights?
(Circle one) 1…..2…..3…..4…..5…..6…..7…..8…..9…..10 (Best)

On an energy level, 10 being the most active and energetic. How would you rate yourself on most days?
(Circle one) 1…..2…..3…..4…..5…..6…..7…..8…..9…..10 (Best)

Have you been diagnosed with a sleep disorder? Yes _____ No _____

*If yes, h*ave you been prescribed CPAP therapy? Yes _____ No _____
If yes, do you wear your CPAP and how often?
every night_____ most nights_____ couple nights per week _____ never_____

Do you experience headaches or migraines regularly? Yes _____ No _____
If yes, how often: rarely _____ sometimes _____ often _____
What medications to you take? ____

Are you happy with the appearance of your teeth? Yes _____ No _____
If no, are you dissatisfied with: *(circle all that apply)*

Color_______ Looks of previous fillings / crowns_______
Shape_______ Condition / Level of gums_______
Spacing_______ Other___________________________________
Crowding_______

Are you interested in knowing more about our home whitening system? Yes _____ No _____

Have you noticed a bad taste/odor in your mouth on a frequent basis? Yes _____ No _____

Are you regularly involved in sports? Yes _____ No _____
List sports? ____
Would you like to know more about our custom athletic sportsguards for you or a family member?
Yes _____ No _____
Are you interested in knowing about permanent tooth replacement? Yes _____ No _____
or implant tooth replacement? Yes _____ No _____

Signature____Date________________________