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DENTAL HISTORY

Answering these questions allows us to treat you on a more personal basis. This information is for our records and considered confidential. Thank you for taking the time to complete the questionnaire.

What is the reason for your visit today? _____

Are you having any pain or discomfort now? Yes No

Date of your last dental visit _____ cleaning Yes No

x-rays Yes No

what else was done?_____

Do you have problems with any of the following?

Bad breath	Yes	No	Headaches, neck pain	Yes	No
Bleeding gums	Yes	No	Loose or shifting teeth	Yes	No
Broken fillings	Yes	No	Sensitivity to cold	Yes	No
Clicking, popping jaw	Yes	No	Sensitivity to hot	Yes	No
Discolored teeth	Yes	No	Sensitivity to biting	Yes	No
Food packs between teeth	Yes	No	Sensitivity to sweets	Yes	No
Grinding, clenching teeth	Yes	No			

How often do you brush? _____ floss_____

Have you had periodontal (gum) surgery? Yes No

Dentist Name _____ Year of Surgery _____

Have you had orthodontics? Yes No

Dentist Name _____ Year of Treatment _____

Do you have any oral habits	Smoking	Yes	No	Hard candy	Yes	No
	Gum chewing	Yes	No	Bite fingernails	Yes	No
	Tobacco	Yes	No			

Have you had any unpleasant dental experiences? Yes_____ No

Any aspects of dentistry you strongly dislike? Yes_____ No

Please circle one

1. I think the appearance of my teeth is excellent
2. I am satisfied with the appearance of my mouth
3. I am dissatisfied with the appearance of my mouth

1. I will do anything to keep my natural teeth
2. I want to keep my teeth but have a certain budget of time and/or money
3. Keeping my teeth is not a priority

Are there any other questions or concerns? _____

_____

Creating healthy beautiful smiles in a family environment