DENTAL HEALTH INFORMATION

Please circle YES or NO for each of the following questions

Reason for your visit_____
_____
When was your last dental visit?_____
_____
Have you had dental x-rays in the last year?_____
3 years?_____
Have you ever had serious problems associated with previous dental treatment? YES NO
If so, please explain:_____
_____
_____
Are you apprehensive about dental treatment?
YES NO

How often do you brush your teeth?_____

What texture brush do you use? Soft Medium Hard

How often do you floss?_____

Do your gums bleed while brushing? YES NO

Do your gums bleed while flossing? YES NO

Do you feel pain to any of your teeth while brushing or flossing them? YES NO

Are your teeth sensitive to heat, cold, sweets, or pressure? (Please circle)

Do you avoid brushing any part of your mouth because of pain? YES NO

If so, what part?_____

Do you have loose, chipped, or shifted teeth? (circle)
YES NO

Have you worn braces on your teeth? YES NO

Do you chew on only one side? YES NO

If so, please explain:_____

Do you smoke or use any tobacco products? YES NO

Are you unhappy with the appearance of your teeth?
YES NO

Do you have discolored teeth that bother you? YES NO

Would you like your smile to look different or better?
YES NO

Do you grind your jaws while sleeping? YES NO

Do you clench your teeth during the day? YES NO

Do your jaws ever feel tired or sore? YES NO

Are you wearing removable dental appliances? YES NO

Do you have headaches? YES NO

If yes, how many headaches per week?_____

Or per month?_____

Do you lose or break fillings? YES NO

Do you gag easily? YES NO

Do you snore so much each night that your sleep is disturbed? YES NO

Please use this space to add anything that you feel is important:_____
_____
_____
_____
_____
_____
_____
_____