

DENTAL HISTORY

What is your main dental concern? _____

When was your last visit to a dentist? _____

What was done? _____

Have you ever had any serious problems associated with previous dental treatment?

___ yes ___ no If yes, please explain _____

Have you ever lost any permanent teeth? ___ yes ___ no Why?

Have the lost teeth been replaced? ___ yes ___ no If so, by what?

Any complications with extractions? ___ yes ___ no If yes, explain.

How often do you brush your teeth? _____

How often do you floss? _____

Do you feel any pain to any of your teeth when brushing or flossing? ___ yes ___ no

Are your teeth sensitive to ___ heat ___ cold ___ sweets ___ sour ___ other

Do your gums ever bleed? ___ yes ___ no

Have you had gum treatment? ___ yes ___ no If yes, when _____

How long do you use a toothbrush before replacing it? _____

What type of bristle do you use? ___ soft ___ medium ___ hard

Have you ever had your teeth straightened? ___ yes ___ no If yes, when

Do you chew on one side of your mouth? ___ yes, only one side ___ no, on both sides

If yes, explain. _____

Does food wedge between your teeth? ___ yes ___ no

Do you ever lose fillings? ___ yes ___ no If yes, explain.

Have you ever had a broken tooth? ___ yes ___ no

Do you clench or grind your teeth while sleeping or during the day? ___ yes ___ no

Do you feel you have bad breath or an unpleasant taste in your mouth? ___ yes ___ no

Do you usually have cavities? ___ yes ___ no

Do you gag easily? ___ yes ___ no

Do you drink tea, soda, or coffee? ___ no ___ occasionally ___ frequently

Are you familiar with the term "Preventive Dentistry"? ___ yes ___ no

Do you like your smile? ___ yes ___ no

What are your dental goals?

Is there anything you would like your dentist to know?

Date _____ Signature _____

