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DENTAL HISTORY

Thank you for selecting our dental healthcare team. Please respond to the following dental history questionnaire, designed to open a discussion of your dental concerns. Should you need assistance, we are glad to help.

Your current dental health is: Good Fair Poor

Describe your current dental problem(s) or concern(s):

When was your last dental hygiene appointment? _____

What dental aids do you use? Electric toothbrush toothpicks proxibrushes

- | | | |
|-----|----|--|
| Yes | No | Have you ever had root planing (deep cleaning) done? |
| Yes | No | Have you been experiencing pain or discomfort related to your teeth, gums or jaw joints? |
| Yes | No | Do you have a bite plate or mouth guard? |
| Yes | No | Have you had clicking, popping or pain in your jaw joint or muscles? |
| Yes | No | Have you noticed any mouth odors (halitosis) or bad tastes? |
| Yes | No | Are your gums red, swollen, glossy or tender? |
| Yes | No | Do your gums bleed or hurt? |
| Yes | No | Have your parents ever experienced gum disease or tooth loss? |
| Yes | No | Do you frequently experience cold sores, blisters or any other oral lesions? |
| Yes | No | Have you noticed any loose teeth? |
| Yes | No | Have you noticed a change in your bite? |
| Yes | No | Do you clench or grind your teeth while awake or asleep? |
| Yes | No | Have you experienced a serious injury to the mouth or head? |
| Yes | No | Would you like to keep your natural teeth for as long as you live? |
| Yes | No | Do you get frustrated that you need work done every time you go to the dentist? |
| Yes | No | Are you satisfied with your teeth's appearance? |
| Yes | No | Would you like to have whiter teeth? |
| Yes | No | Would you like your teeth to be straighter? |
| Yes | No | Do you have metal or discolored fillings that you are unhappy with? |
| Yes | No | Do you have crowns or bridges that are unattractive or unnatural-looking? |
| Yes | No | Do you sometimes feel uncomfortable with the appearance of your smile? |
| Yes | No | Do you have unattractive spaces between your teeth? |
| Yes | No | Do you experience headaches, neckaches or shoulder aches? |
| Yes | No | Do you have difficulty opening or closing your mouth? |
| Yes | No | Have you ever had periodontal treatment? |
| Yes | No | Are you apprehensive about dental treatment? If so, what are concerns? |
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Signature

Date