DENTAL HEALTH INFORMATION

Patient's Name: _____
Last First MI Preferred Name

Complete and answer the following questions, which will allow our doctors to treat you on a more individual basis, providing appropriate treatment for your individual needs. Your answers are for our records only and will be considered CONFIDENTIAL.

1. Are you having any discomfort? YES NO
2. Have you ever had any serious problems associated with previous dental treatment? YES NO
3. Does dental treatment make you nervous? YES NO
4. I think my present state of oral health is: EXCELLENT GOOD POOR
5. Date of your last dental visit? _____ Service Provided? _____
6. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? YES NO
7. How often do you brush your teeth? _____ Brush type? HARD MEDIUM SOFT
8. How often do you floss? _____
9. Do you avoid brushing any part of your mouth due to discomfort/pain? YES NO
   If yes, what part? _____
10. Do you only chew on one side of your mouth? YES NO
    If yes, please explain: _____
11. Do you have or have you ever had any of the following:

Bleeding or sore gums	YES	NO	Loose teeth	YES	NO
Unpleasant taste/breath	YES	NO	Sensitive to hot	YES	NO
Burning tongue/lips	YES	NO	Sensitive to cold	YES	NO
Frequent blisters on lips/mouth	YES	NO	Sensitive to sweets	YES	NO
Swelling/Lumps in mouth	YES	NO	Sensitive to biting	YES	NO
Orthodontic Treatment	YES	NO	Food Impaction	YES	NO
Biting cheeks/lips	YES	NO	Clicking/popping jaw	YES	NO
Difficulty opening/closing jaw	YES	NO			

12. Do you grind your jaws while sleeping? YES NO
13. Do you clench your teeth during the day? YES NO
14. Do your jaws ever feel tired? YES NO
15. Are you wearing removable dental appliances? YES NO
16. Do you have headaches? YES NO
    If yes, how many per week? _____Month? _____
17. Do you have earaches, neck or jaw pain? YES NO
18. Do you lose or break fillings? YES NO
19. Do you gag easily? YES NO
20. Do you snore so much each night that you lose sleep? YES NO
21. Do you smoke or use any tobacco products? YES NO
22. Are you unhappy with the appearance of your teeth? YES NO
    If yes, why? _____
23. Does the color of your teeth bother you? YES NO
24. Would you like your smile to look different or better? YES NO
    If yes, why? _____
25. These are things that are important to me about my dental health: _____
26. Please circle the number in order of reasons that may keep you from having dental treatment:
    (1) Most (2) Above average (3) Average (4) Least
    Fear of pain: 1 2 3 4 Lack of concern: 1 2 3 4 Cost of treatment: 1 2 3 4 Missing work: 1 2 3 4
27. Please use this space to add anything that you feel is important:
    _____