

DENTAL HISTORY

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|---|----------------|----|---------|------------------|
| 1. Are you having pain or discomfort from your teeth at this time? | YES | NO | UNKNOWN | WHERE? _____ |
| 3. Do you feel nervous about having dental treatment? | YES | NO | UNKNOWN | |
| 4. Have you ever had a bad experience in the dental office? | YES | NO | UNKNOWN | WHEN? _____ |
| 5. Do your gums bleed? | YES | NO | | |
| 6. Have you noticed bad odors or tastes? | YES | NO | | |
| 7. Do you have any teeth sensitive to heat, cold or sweets? | YES | NO | | WHICH? _____ |
| 8. Do you have any loose teeth? | YES | NO | | WHERE? _____ |
| 9. Are you satisfied with the appearance of your teeth? | YES | NO | | |
| 10. Does food get caught between your teeth? | YES | NO | | WHERE? _____ |
| 11. Are you aware of clenching or grinding your teeth? | YES | NO | | WHEN? _____ |
| 12. Would it bother you if you had to lose your teeth and wear false ones? | YES | NO | | |
| 13. Do you brush your teeth at least twice daily? | YES | NO | | HOW OFTEN? _____ |
| 14. Do you use dental floss, a proxabrush or toothpicks? | YES | NO | | HOW OFTEN? _____ |
| 15. Do you want to keep your teeth? | YES | NO | | |
| 16. Have you ever had periodontal (gum) disease? | YES | NO | UNKNOWN | WHEN? _____ |
| 17. Are you aware of any history of periodontal (gum) disease in your family. | YES | NO | UNKNOWN | |
| 18. When did you last have your teeth cleaned? | _____ | | | |
| 19. How often do you have your teeth cleaned in a year? | _____ | | | |
| 20. Are you willing to spend 15 minutes per day in order to keep your teeth? | YES | NO | UNKNOWN | |
| 21. What is your chief complaint concerning your mouth or teeth? | _____
_____ | | | |
| 22. Based on what your dentist has told you and what you know about your mouth, please rate the condition of your mouth on a scale of 1 to 10 where 10 is severe disease (anticipated loss of some teeth) and 1 is optimal. | _____ | | | |