

## DENTAL HEALTH

When was your last dental visit? \_\_\_\_\_

How often did you see your dentist? \_\_\_\_\_

Are you having any dental problems that require immediate attention? \_\_\_\_\_

Do any of the following cause tooth discomfort? Hot \_\_\_\_\_ Cold \_\_\_\_\_ Sweets \_\_\_\_\_ Chewing \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ Floss? \_\_\_\_\_ Water Jet? \_\_\_\_\_

Do your gums bleed while cleaning? \_\_\_\_\_

Do your gums ever feel tender or swollen? \_\_\_\_\_

Have you had periodontal treatment? \_\_\_\_\_ When? \_\_\_\_\_

Do you clench or grind your teeth? \_\_\_\_\_

Do your jaws ever feel tired or ache? \_\_\_\_\_ Click or pop? \_\_\_\_\_

Can you chew on both sides of your mouth? \_\_\_\_\_ Comfortably? \_\_\_\_\_

Do you have frequent headaches? \_\_\_\_\_ Earaches? \_\_\_\_\_

Have you ever had orthodontic treatment (braces)? \_\_\_\_\_ When? \_\_\_\_\_

Do you lose fillings or break fillings? \_\_\_\_\_

Do you usually have many cavities? \_\_\_\_\_

Do you have any loose teeth? \_\_\_\_\_ Cracked or broken teeth? \_\_\_\_\_

Do you have any noticeable wear on your teeth? \_\_\_\_\_ Food traps \_\_\_\_\_

Do you have any missing teeth? \_\_\_\_\_ Have they been replaced? \_\_\_\_\_

If so, how? Fixed bridge \_\_\_\_\_ Removable partial \_\_\_\_\_ Full denture \_\_\_\_\_ Dental implant \_\_\_\_\_

Are you comfortable with the replacement? \_\_\_\_\_ Please describe \_\_\_\_\_

Are you a smoker? \_\_\_\_\_ Use tobacco products? \_\_\_\_\_

How do you feel about the appearance of your smile? \_\_\_\_\_

Have you ever had any cosmetic dentistry done to improve your appearance? \_\_\_\_\_

If yes, are you pleased with the result? \_\_\_\_\_ Please comment \_\_\_\_\_

Have you ever had any unpleasant dental experience? \_\_\_\_\_

Please add anything you feel is important: \_\_\_\_\_

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Signature \_\_\_\_\_