DENTAL HISTORY

1. Have you visited the dentist within the last year?……

2. What was done at your last dental visit? _____

3. Is there anything that is bothering you at this time?……

4. Are you pleased with the position (spacing, crowding) of your teeth? ……

5. Are you pleased with the color of your teeth? ……..

6. Are you pleased with the color of your fillings? ……

7. Would you like to know what options are available to you to create a more attractive smile? ……..……

8. Are you pleased with the appearance of your gums? ……..

9. Do you ever notice that your gums bleed? ……

10. Have you ever noticed any irritation, discomfort, or pain in your gums? ……

11. Have any of your gums receded? ……

12. Do you have any loose teeth? ……

13. Does your jaw ever make any noises like popping or clicking when you open or close it?……..……

14. Do you ever get a tired feeling in your face or jaw? ……..……

15. Are you aware of any excessive wear on any of your teeth? ……..

16. Do you ever grind or clench your teeth? ……

17. Do you have frequent headaches? ……

18. Do you have pain in or near your ear? ……..

19. Do you have difficulty opening or closing, or have limited motion of your jaw? ……

20. Do you lose or break fillings? ……

21. Have you ever broken or fractured a tooth? ……

22. Do you usually have many cavities? ……

23. Have you lost any permenant teeth? ……

24. Do you wear any bridges, partials, or dentures? ……..

25. Does anyone in your immediate family wear partials or dentures? ……

26. Are any of your teeth sensitive to hot, cold sweet, biting pressure, toothbrushing, etc.? ……

27. Have you ever worn braces? ……

28. Have you ever been shown how to prevent future gum or decay problems? ……

29. How often do you brush your teeth? _____

30. Rate your level of anxiety for dental appointments on the following scale. 1 2 3 4 5 6 7 8 9 10

none extreme

Please add anything you feel is important._____

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