Patient Name: ____________________________

DENTAL HISTORY

1. Are you having pain or discomfort from your mouth at this time? YES NO UNKNOWN WHERE?______
2. Do you feel nervous about having dental treatment? YES NO
3. Have you ever had a bad experience in the dental office? YES NO UNKNOWN WHEN?_______
4. Have you had swollen areas on your gums, gum boils or abscesses? YES NO 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 teeth? 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 UNKNOWN
16. Have you ever had periodontal (gum) treatment? 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 a day in order to keep your teeth? YES NO UNKNOWN
21. What is your chief complaint concerning your mouth or teeth? ______________________________________

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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. ___________________