DENTAL HEALTH

Reason for visit: _____

When was your last dental visit? _____

When was your last full mouth x-ray taken? _____ Where? _____

Have you ever had any serious problem associated with previous dental treatment? ..... Yes ☐ No ☐

If so, explain: _____

_____

How often do you brush your teeth? _____

What texture brush do you use? Soft ☐ Medium ☐ Hard ☐ Nylon ☐ Natural ☐

How often do you floss? _____

Do your gums bleed while brushing ..... Yes ☐ No ☐

Do your gums bleed while flossing ..... Yes ☐ No ☐

Do you avoid brushing any part of your mouth because of pain? ..... Yes ☐ No ☐

If yes, what part? _____

Do you feel twinges of pain when your teeth come in contact with:

a) hot foods or liquids, i.e., soup, coffee, tea, etc.? ..... Yes ☐ No ☐

b) cold foods or liquids, i.e., ice cream, cold fruit, etc.? ..... Yes ☐ No ☐

c) sweets, i.e., candy, fruit, sweet desserts, etc.? ..... Yes ☐ No ☐

d) sours, i.e., lemons, limes, grapefruit, etc.? ..... Yes ☐ No ☐

Do you feel pain to any of your teeth when brushing or flossing them? ..... Yes ☐ No ☐

Do you chew on only one side of your mouth? ..... Yes ☐ No ☐

If yes, explain _____

_____

Do your gums feel tender or swollen? ..... Yes ☐ No ☐

Do you clench or grind your jaws while sleeping or during the day? ..... Yes ☐ No ☐

Do your jaws ever feel tired? ..... Yes ☐ No ☐

Do you wear dentures? ..... Yes ☐ No ☐

Do you usually have many cavities? ..... Yes ☐ No ☐

Do you lose fillings or break fillings? ..... Yes ☐ No ☐

Do you gag easily? ..... Yes ☐ No ☐

Are you familiar with the term "preventive dentistry"? ..... Yes ☐ No ☐

Please add anything you feel is important: _____

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(Patient signature)