DENTAL HEALTH HISTORY

1. Reason for visit today? _____

2. When was your last dental visit? _____

3. Of the following sentences, which one best describes the type of dentistry you want for yourself:
   - ☐ I want to have necessary dental care to keep my mouth comfortable and out of pain.
   - ☐ I want dental care that maintains my present teeth in good health.
   - ☐ I want dental care that maintains my present teeth in good health and replaces any missing teeth or tooth that I may have to lose in the future.
   - ☐ I want the highest quality of dental care to prevent dental problems, restore my remaining teeth to optimum health, and replace any teeth that are missing or that I may lose.

4. What do you think is the present health of your teeth and related tissue (gums, bone support, etc.)?
   ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

5. What is the level of dental treatment that you think you have received in the past?
   ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

6. Have you ever had any serious problems associated with previous dental treatment? If so, explain: _____

7. Are you familiar with the term, “Preventive dentistry”? ☐ YES ☐ NO

8. How do you feel about the appearance of your teeth?
   ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

9. Are you familiar with the term “cosmetic dentistry”? ☐ YES ☐ NO

10. Would you desire dental treatment to improve the appearance of your teeth? ☐ YES ☐ NO ☐ MAYBE

11. How often do you brush your teeth? _____

12. What texture brush do you use? ☐ SOFT ☐ MEDIUM ☐ HARD ☐ NYLON ☐ NATURAL

13. How often do you floss? _____

14. Do your gums bleed while brushing? _____

15. Do your gums bleed while flossing? _____

16. Do you avoid brushing any part of your mouth because of pain? YES NO If yes, what part? _____

17. Do you feel twinges of pain when your teeth come in contact with :
   - ☐ hot foods or liquids (soup, coffee, tea, etc.)?
   - ☐ cold foods or liquids (ice cream, cold fruit, etc.)?
   - ☐ sweets (candy, fruit, sweet desserts, etc.)?
   - ☐ sours (lemons, limes, grapefruit, etc.)?

18. Do you feel pain on any of your teeth when brushing or flossing? _____

19. Do you chew on only one side of your mouth? ☐ YES ☐ NO If yes, explain: _____

20. Do your gums feel tender or swollen? _____

21. Do you clench or grind your jaws while sleeping or during the day? _____

22. Do your jaws ever feel tired? _____

23. Do you wear dentures? ☐ YES ☐ NO

24. Do you usually have many cavities? _____

25. Do you lose fillings or break fillings? _____

26. Do you gag easily? _____

27. Please add any other information you feel is pertinent concerning your dental history. _____

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