YOUR DENTAL HEALTH

DATE OF LAST: Dental Visit _____ Dental Cleaning _____ Dental X-Rays _____

What was done at your last dental visit? _____

HOW OFTEN DO YOU HAVE DENTAL EXAMINATIONS, CLEANINGS? _____

How often do you brush your teeth? _____ How often do you floss? _____

Which do you use? ❒ Regular Toothbrush ❒ Electric Toothbrush ❒ Toothpick

❒ Floss ❒ Other _____

DO YOU HAVE DENTAL PROBLEMS NOW? ❒ Yes ❒ No

If yes, please describe: _____

_____

DO YOUR GUMS EVER:

Feel irritated or tender? ❒ Yes ❒ No

Bleed anytime you brush? ❒ Yes ❒ No

WHAT DO YOU DRINK MOST OFTEN DURING THE DAY? _____

With Meals? ❒ Yes ❒ No Between Meals? ❒ Yes ❒ No Sip Frequently? ❒ Yes ❒ No

ARE ANY OF YOUR TEETH SENSITIVE TO:

Hot or Cold? ❒ Yes ❒ No Where _____

Sweets? ❒ Yes ❒ No Where _____

Biting or chewing? ❒ Yes ❒ No Where _____

Have you noticed any mouth odors or bad tastes? ❒ Yes ❒ No Where _____

Does food catch between your teeth? ❒ Yes ❒ No Where _____

DO YOU:

Chew ice?	❒ Yes	❒ No
Bite your nails or any hard object?	❒ Yes	❒ No
Bite thread or fishing line with your teeth?	❒ Yes	❒ No
Clench or grind your teeth while awake?	❒ Yes	❒ No
Ever rest your teeth together?	❒ Yes	❒ No
Clench or grind your teeth while sleeping?	❒ Yes	❒ No
Have tired jaws especially in the morning?	❒ Yes	❒ No
Have tired jaws while chewing?	❒ Yes	❒ No
Smoke/chew tobacco?	❒ Yes	❒ No
Chew on both sides of your mouth?	❒ Yes	❒ No
Lose or break fillings?	❒ Yes	❒ No
Have any cracked or broken teeth?	❒ Yes	❒ No
Have any noticable wear on your teeth?	❒ Yes	❒ No
Chew gum	❒ Yes	❒ No
Is it sugarless?	❒ Yes	❒ No

HAVE YOU EXPERIENCED:

Problems with your jaw joints?	❒ Yes	❒ No
Clicking or popping of the jaw?	❒ Yes	❒ No
Pain? (Joint, ears, side of face)	❒ Yes	❒ No
Difficulty in opening or closing your mouth?	❒ Yes	❒ No
Headaches, neckaches or shoulder aches?	❒ Yes	❒ No
Noise in your jaw joints?	❒ Yes	❒ No
Ringing in your ears?	❒ Yes	❒ No
Locking of your jaw open or closed?	❒ Yes	❒ No
A change in your bite?	❒ Yes	❒ No

HAVE YOU EVER HAD:

Orthodontic (braces) treatment?	❒ Yes	❒ No
Oral surgery (extractions)?	❒ Yes	❒ No
Peridontal (gum) care?	❒ Yes	❒ No
Your bite adjusted?	❒ Yes	❒ No
A bite splint or mouth guard?	❒ Yes	❒ No
Nitrous oxide (laughing gas)?	❒ Yes	❒ No

If yes, how did you like it? _____