DENTAL HISTORY

Your current dental health is: Good Fair Poor

Describe your current dental problem(s) or concern(s):

When was your last dental hygiene appointment? ________________

Yes No Have you ever had root planning (deep cleaning) done?

Yes No Do you have a bite plate or mouth guard?

Yes No Have you had clicking, popping or pain in your jaw joint or muscles?

Yes No Have you noticed any mouth odors (halitosis) or bad tastes?

Yes No are your gums red, swollen, glossy or tender?

Yes No Do your gums bleed or hurt?

Yes No have your parents ever experienced gum disease or tooth loss?

Yes No do you frequently experience cold sores, blisters or any other oral lesions?

Yes No Have you noticed any loose teeth?

Yes No Have you noticed a change in your bite?

Yes No Do you clench or grind your teeth while awake or asleep?

Yes No Have you experienced a serious injury to the mouth or head?

Yes No would you like to keep your natural teeth for as long as you live?

Yes No Do you get frustrated that you need work done every time you go to the dentist?

Yes No are you satisfied with your teeth's appearance?

Yes No would you like to have whiter teeth?

Yes No would you like your teeth to be straighter?

Yes No Do you have metal or discolored fillings that you are unhappy with?

Yes No Do you have crowns or bridges that are unattractive or unnatural-looking?

Yes No Do you sometimes feel uncomfortable with the appearance of your smile?

Yes No Do you have unattractive spaces between your teeth?

Yes No do you experience headaches, neck aches or shoulder aches?

Yes No Do you have difficulty opening or closing your mouth?

Yes No Have you ever had periodontal treatment?

Yes No are you apprehensive about dental treatment? If so, what are concerns?