NAME:_____ Date:_____

DENTAL HISTORY

Please check any of the following problems that apply to you:

- o Sensitivity (hot, cold, sweet)
- o Tooth pain or discomfort when chewing
- o Headaches, earaches, neck pain
- o Jaw joint pain
- o Mouth ulcers or cold sores
- o Broken tooth or fillings
- o Grinding or clenching teeth
- o Bleeding, swollen or irritated gums
- o Loose, tipped or shifting teeth
- o Bad breath or bad taste in your mouth
- o Insomnia
- o Do you have trouble falling asleep?
- o Do you have trouble staying asleep?
- o Trouble sleeping or difficulty staying asleep
- o Sleep apnea
- o Nasal oxygen use

Have you or any family members had any of the following?

- o Dentures/ partial dentures
- o Braces
- o Periodontal (gum) treatments
- o History of heart disease
- o History of diabetes

Please share the following dates:

Your last cleaning:_____
Your last oral cancer screening:_____
Your last complete x-rays:_____
Your last periodontal screening:_____

Why did you leave your previous dentist?

_____

If you could change your smile, you would:

- o Make my teeth brighter
- o Make my teeth straighter
- o Close spaces
- o Replace black metal fillings with natural, tooth-colored fillings
- o Replace chipped teeth
- o Replace missing teeth
- o Replace old crowns that do not match
- o Have a smile makeover

What is the most important thing to you about your dental visit today?

_____

On a scale of A-D with A being the highest rating:

How important is your dental health to you?

A B C D

Where would you rate your current dental health?

A B C D

What is the most important thing to you about your future smile and dental health?

_____
_____
_____