

1. Nature of your dental problem \_\_\_\_\_
2. Are you having pain or discomfort at this time? Where? \_\_\_\_\_ Y N
3. Are any of your teeth sensitive too hot, cold, sweet or sour? Where? \_\_\_\_\_ Y N
4. Do you have sores in or around your mouth? Where? \_\_\_\_\_ Y N
5. Do your gums bleed? If so, when? \_\_\_\_\_ Y N
6. Have you ever had periodontal treatment? If yes,
  - When? \_\_\_\_\_
  - What? \_\_\_\_\_
  - Where? \_\_\_\_\_
7. Do you have any breathe odor or unpleasant taste? \_\_\_\_\_ Y N
8. Do you have loose teeth? Where? \_\_\_\_\_ Y N
9. Do you have any popping, grinding, locking or pain in either jaw joint? \_\_\_\_\_ Y N
10. Has your dental care been regular? \_\_\_\_\_ Y N
11. How long ago was your last dental cleaning? \_\_ 3 mo \_\_ 4 mo \_\_ 6 mo \_\_ Other \_\_\_\_\_
12. How often do you have your teeth cleaned? \_\_ 3 mo \_\_ 4 mo \_\_ 6 mo \_\_ Other \_\_\_\_\_
13. When was the last time you had dental x-rays taken? \_\_ 6 mo \_\_ 1 yr \_\_ 5 yr \_\_ Other \_\_\_\_\_
14. How many times a day do you brush your teeth? \_\_ once \_\_ twice \_\_ three \_\_ Other \_\_\_\_\_
15. Do you floss? Y N      How often? \_\_ Daily \_\_ 2-3 x wk \_\_ weekly \_\_ Other \_\_\_\_\_
16. Do you have any removable dental appliances/partial/dentures? \_\_\_\_\_ Y N
17. Have you ever had orthodontic treatment (braces)? When? \_\_\_\_\_ Y N
18. Do you smoke? Y N      If yes, how much? \_\_\_\_\_
19. Have you smoked in the past? Y N      Quit Date \_\_\_\_\_
20. Do you chew tobacco, use snuff or smoke cigars? Y N      How often? \_\_\_\_\_
21. Have you ever had serious problems with dental treatment? \_\_\_\_\_ Y N
 

Please explain \_\_\_\_\_

\_\_\_\_\_
22. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? \_\_\_\_\_

I certify that the above information is complete and accurate.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date