

Patient Name _____ Date _____

DENTAL HISTORY

1. Are you having discomfort or concerns at this time? YES NO
a. If so, please describe _____

2. Name and address of your last dentist (optional) _____
3. When were you last at the dentist? _____
4. What was done then? _____
5. Did he/she take radiographs (x-rays)? YES NO
6. Have you had your teeth straightened? YES NO
7. Have you had periodontal (gum, pyorrhea) treatment? YES NO
8. Have you lost any permanent teeth? YES NO
9. Have you had any difficulties with extractions? (excessive bleeding, etc.)? YES NO
10. Do you have
a. Fixed Bridge? - Date Made _____ YES NO
b. Upper partial? - Date Made _____ YES NO
c. Lower partial? - Date Made _____ YES NO
d. Upper denture? - Date Made _____ YES NO
e. Lower denture? - Date Made _____ YES NO
11. Do you brush? YES NO
a. How often? _____
12. Do you use dental floss? YES NO
a. How often? _____
13. Do your gums bleed? YES NO
14. Does food wedge between your teeth? YES NO
a. Where? _____
15. Are your teeth sensitive to hot, cold, biting, pressure? YES NO
16. Are you aware of any swelling or lumps in your mouth? YES NO

PREVENTION

1. How do you feel about your teeth?
a. The way they look _____
b. The way they feel _____
2. How do you feel about dentures? _____
3. Does anyone in your family wear dentures? _____
4. Do you feel that someday you will have dentures? YES NO
5. Have you been made aware of clenching or grinding your teeth during the night or day? YES NO
6. Do you have chronic headaches, or neck and shoulder pains? YES NO
7. Do you ever wake up with an awareness of, or about, your teeth or jaw like you've had them clenched in your sleep? YES NO
8. Do you have, or have you ever had, pain in your jaw joint or the sides of your face (in and about the ears)? YES NO
9. Do you have a clicking jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely? YES NO

(continued on other side)

10. Which side do you chew on? Right ____ Left ____ Both ____

11. Do you know the meaning of traumatic occlusion?..... YES NO

DIETARY HABITS

Do you smoke? _____ How much ? _____

What did you eat for breakfast today? _____

How many bottles of soft drinks do you drink daily? _____

Do you eat sweets regularly? YES NO

Do you eat sugar-coated cereal? YES NO

How many cups of coffee, tea, or substitute do you drink daily? _____

What do you use in your coffee, tea, or substitute? _____

When do you eat between meals? Morning ____ Afternoon ____

Night ____ Rarely ____

Which supplements do you use?:

Multiple ____ B-Complex ____ Iron ____ Calcium ____ Vitamin A ____ E ____ Vitamin C ____ None ____

APPREHENSION SCREENING

1. Do you have a fear of having dentistry done? YES NO

a. What aspect is frightening (needle, drilling, etc.)? _____

2. Do you have trouble sleeping before an appointment? YES NO

3. Would you like ? :

a. A mild tranquilizer on the night before YES NO

b. A mild tranquilizer on the morning of YES NO

c. Nitrous oxide (gas) during treatment YES NO

CHILD INFORMATION

Nickname _____ School _____ Grade _____

What is child's favorite sport? _____

Favorite Hobby _____ Favorite Person _____

Favorite Fiction Character _____

Signature of patient/parent