

PLEASE CIRCLE YES OR NO

PATIENT NAME: _____

- *** Date of last dental visit & for what _____
1. Are you presently in pain? YES NO
Teeth Jaw Gums Face Other
 2. Have you lost any teeth? YES NO
If the teeth were replaced, how? _____
 3. Is any part of your mouth sensitive to the following? YES NO
Hot Cold Pressure Sweet Sour Other
 4. Do you have a burning sensation in your mouth? YES NO
Have you experienced unusual dryness of the mouth? YES NO
 5. Have you ever had periodontal treatment or gum surgery? YES NO
If YES, when? _____ By whom? _____
 6. Do your gums bleed when you brush your teeth? YES NO
 7. Does food catch between your teeth? Where? _____ YES NO
 8. Are you aware of a bad taste or odor in your mouth? YES NO
 9. Are you aware of any growths or swellings in your mouth? YES NO
If YES, where are they located and how long have they existed?

 10. Are you aware of your jaw clicking, popping or making grating-like noises;
or do your muscles feel tired, stiff or painful? YES NO
 11. Do you clench or grind your teeth during the **day** or **night** YES NO
 12. Are you aware of pain in your neck and/or head YES NO
If yes, where _____
 13. Do you have headaches? YES NO
How often & where _____
 14. What do you like BEST about your teeth? What do you like LEAST?

 15. Do you have any anxieties about dental treatment? YES NO
Please explain, _____
 16. Are you interested in learning how to control dental disease to preserve your
teeth and oral health? YES NO
 17. Do you have any questions or concerns? YES NO
If YES, please explain _____

DENTAL HISTORY