# DENTAL HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Please list your dental complaints, if any: _____
   _____
2. What do you want to accomplish in terms of your oral health? _____
   _____
3. Are you experiencing any pain or discomfort at this time? …….. Y N
4. How do you presently take care of your teeth and gums?
   Flossing Y N How often? _____ Brushing Y N How often? _____ Toothbrush: Hard Soft Power
5. Do you have sensitive teeth? …….. Y N
   If so, when: _____
6. When was your last visit to a dentist? _____
7. What services were provided? _____
8. Who was/were your previous dentist(s) (name/city/state): _____
   _____
9. How did you hear about this practice?
   Radio (Sidney or Oneonta) Pennysaver Daily Star Internet Sign Friend Coworker Family Other
10. Would you like to learn how to prevent tooth decay and control gum disease? ……. Y N

GENERAL RISK – SELF ASSESSMENT

11. Does your mouth seem dry? …….. Y N
12. During the day, do you eat and snack on sugary foods, drinks, gum, or mints? …… Y N
13. Are you nervous about having dental treatment? …….. Y N
14. Have any of your family members had gum disease? …….. Y N
15. Have any of your family members had excessive cavities? …….. Y N

PERIODONTAL RISK – SELF ASSESSMENT

16. Have you had, or have you ever been told that you have “gum disease”, “deep pockets”, or periodontal disease? …….. Y N
17. Currently, do you have sore or bleeding gums? …….. Y N

CARIES RISK – SELF ASSESSMENT

18. Do you seem to have new cavities at each dental check-up? …….. Y N
19. Do you use xylitol or fluoride toothpaste? …….. Y N
20. Do you use xylitol or fluoride oral rinse? …….. Y N
21. Do you live in an area with fluoridated water? …….. Y N
22. Do you have a lot of “fillings”? …….. Y N
23. How long ago did you have your last “filling”? _____