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Name: _____ **Date:** _____

What is the reason for your visit today, what is your concern?

Do you have an area of concern or pain? (circle all that apply)

- Upper Left
- Upper Front
- Upper Right
- Lower Left
- Lower Front
- Lower Right
- Other

1. **Does it hurt to bite on or touch your tooth/teeth together?**

☐ **YES** – please answer the following ……. ☐ **NO** – go to question **2**

- Does it hurt to touch your teeth together even when not chewing food?..... ☐ Yes ☐ No
- Does it hurt to bite when chewing food?.....☐ Yes ☐ No
- Does it only hurt when biting hard food?.....☐ Yes ☐ No
- Does it only hurt when biting hard food in just the right place on the tooth?..☐ Yes ☐ No
- Does it hurt when pressure is released from the tooth?.....☐ Yes ☐ No

2. **Are any of your teeth sensitive to hot or cold?**

☐ **YES** – please answer the following ……. ☐ **NO** – go to question **3**

- Is the tooth heat sensitive?.....☐ Yes ☐ No
- Is the tooth cold sensitive? .....☐ Yes ☐ No
- How long does it take for the pain to go away after the hot or cold if removed?
  ☐ 0 to 30 seconds……. ☐ 30 to 60 seconds……. ☐ Over a minute
- How intense is the cold/hot sensitivity?.....☐ Mild…..☐ Moderate…☐ Severe
- Does hot or cold relieve the symptoms or make the pain go away?.....☐ Yes ☐ No

3. **Gums:**

- Do your gums bleed? ……☐ Yes ☐ No
- Are your gums painful?……☐ Yes ☐ No
- Is the tooth or teeth loose teeth?.....☐ Yes ☐ No
- Does food get caught in between your teeth? ……☐ Yes ☐ No

4. **TMJ:**

- Do you clench or grind your teeth while awake or asleep? ……☐ Yes ☐ No
- Bite your lips or cheeks regularly? ……☐ Yes ☐ No
- Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails, other?) ……..☐ Yes ☐ No
- Is you jaw tired or stiff especially in the morning? ……☐ Yes ☐ No
- Does your jaw click or pop?.....☐ Yes ☐ No
- Do you have difficulty opening or closing your mouth?.....☐ Yes ☐ No
- Have you noticed a change in your bite? ……☐ Yes ☐ No
- Do you have headaches?..... ☐ Yes ☐ No Where? _____

5. **SINUS:**

- Have you had a sinus infection recently?.....……...☐ Yes ☐ No
- Have your allergies been a problem lately? ……☐ Yes ☐ No
- Does the pain or discomfort increase if you change position (bend over, lie down)?.....☐ Yes ☐ No
- Have you had a discharge from your nose? ……..☐ Yes ☐ No
- Have you had sinus drainage recently? ……...☐ Yes ☐ No

6. Have you ever had treatment for and of the following?

- Gum disease?..... ☐ Yes ☐ No
- Wisdom or other teeth removed?..... ☐ Yes ☐ No
- TMJ (temporomandibular joint dysfunction)?..... ☐ Yes ☐ No
- Worn a splint or a night guard?..... ☐ Yes ☐ No
- Tooth straightening (such as braces) ……..☐ Yes ☐ No
- An injury to the mouth or head?..... ☐ Yes ☐ No

7. Have you had dental x-rays in the last 5 years?

☐ **YES** – please answer the following ……. ☐ **NO** – go to question 8

- When was the x-ray taken? ……_____ or don't remember?
- Was it an x-ray of just this tooth or of the whole mouth?...☐ Just this tooth….☐ The whole mouth.
- Have you had full mouth x-rays (12 to 20 xrays of your entire mouth)?.☐ Yes… ☐ No. Date: _____
- Have you had a panoramic x-ray (a machine circle around your head…☐ Yes…☐ No. Date: _____
- Where were the x-rays taken: Dentist _____
- Phone _____ City _____ State:_____

8. Are you concerned about or do you wish you could change the appearance of your teeth?

☐ **YES** – please answer the following ……. ☐ **NO** – go to question **10**

- What is your concern? _____
- How do you feel about the color of your teeth? _____
- Are your teeth crowded? ….☐ Yes….. ☐ No …….. ► Does it bother you? ☐ Yes ☐ No
- Is there anything else you don't like or wish you could change about your teeth? _____

_____

10. Do want to keep your teeth all of your life? …….☐ Yes ☐ No

11. Are you anxious or fearful about having dental treatment?

☐ **YES** – please answer the following ……. ☐ **NO** – go to questions **12**

- Have you had an upsetting dental experience?..... ☐ Yes ☐ No
  - What happened? _____
- Do you feel nervous about dental treatment? . ☐ A little…..☐ somewhat…..☐ a lot…..☐ terrified
- What concerns you most? _____
- Have you ever used nitrous oxide (laughing gas) or sedation for dental visits?.... ☐ Yes ☐ No
  - If so, how well did it work?.....☐ no effect…...☐ fair…...☐ good…....☐ very well
- Do you want to be sedated for your dental visits?..... ☐ Yes….. ☐ No….. ☐ Maybe

12. Do you have any other concerns about dental treatment?

13. Do you have concerns that keep you from seeking dental treatment?

Caries Risk Assessment: (help us understand how to better help you. We will not judge or reprimand you, that is not our purpose.)

Do you drink sodas/pop? ☐Yes ☐ No ► ☐diet ☐sugared? ►how many per day? _____

Coffee or tea with sugar? ☐Yes ☐ No ► how many per day? _____

Fruit juices (apple, orange, etc.)? ☐Yes ☐ No ► how many per day? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you use toothpaste with fluoride? _____

Do you chew gum? ☐Yes ☐ No ► What brand? _____

Is your water fluoridated? ☐Yes ☐ No Do you drink bottled or filtered water? ☐Yes ☐ No

Do you have a dry mouth? ☐Yes ☐ No When?... ☐Sleeping ☐Morning ☐Daytime

Do you have acid reflux or GERD (gastro esophageal reflux disease)? ☐Yes ☐ No

Do you have bulimia or vomit frequently? …. ☐Yes ☐ No