chesterfield woodlake dental

Dental History for _____

When was your last dental exam?
How often do you have your teeth cleaned?
Are you experiencing any dental pain now? * Yes * No
If so, where? * Upper Left * Upper Front * Upper Right
* Lower Left * Lower Front * Lower Right
Is the pain associated with?
*Biting * Sweets * Cold *Heat * Air
Are you taking any medications for this pain? * Yes * No
Are you apprehensive about dental treatment? * Yes * No
Does food become lodged between teeth? * Yes * No
Do you have difficulty chewing your food? * Yes * No
Do you avoid chewing in part of your mouth due to pain? * Yes * No
Do you avoid brushing or flossing part of your mouth due to pain? * Yes * No
Does your breath concern you? * Yes * No
Have you ever been diagnosed with periodontitis or periodontal disease? * Yes * No
Have you ever noticed slow healing sores in your mouth? *Yes * No
Do you smoke or chew tobacco? *Yes * No
Do you brush your teeth at least once a day? * Yes * No
Do you floss at least once a day? *Yes * No
Do you clench or grind your teeth? * Yes * No
Does your jaw hurt when you chew or open it wide to take a bite? * Yes * No
Do you know of any reason to take a pre-medication prior to medical or dental care? * Yes * No
Do you take any medication to thin your blood such as Aspirin or Coumadin? *Yes *No
What would you change about your smile?

What did you like about your previous dentist?

What did you dislike about your previous dentist?

Are you interested in straightening or moving your teeth? *Yes * No
Are you interested in whitening your teeth? * Yes * No