Patient Name:_____ Date: _____

Please answer the following questions:

1. How often do you brush? _____
2. How often do you floss? _____
3. What brand of toothpaste do you use_____
4. Do you routinely use a mouthwash? If so, which one_____
5. What other home care devices do you use? (ie: Electric toothbrush, Oral irrigator)
   _____

# Habits

**Key:**
*Never*: I've never had the habit
*Potential*: I do it sometimes
*Manifested*: I do it a lot
*History*: I used to do it, but don't anymore

| | ***Never*** | ***Potential*** | ***Manifested*** | ***History*** |
|---|---|---|---|---|
| Grind / Clench Your Teeth | | | | |
| Mouth Breather | | | | |
| Bulimia / Anorexia | | | | |
| Tobacco Use | | | | |
| Bite Nails | | | | |
| Toothpick / Stimulator | | | | |
| Chewing gum | | | | |
| Candy | | | | |
| Soft Drinks, if so what kind | | | | |
| Other Habits | | | | |

## History

| **Have you ever had:** | **Yes** | **No** |
|---|---|---|
| Orthodontic treatment (Braces) | | |
| Night Guard | | |
| Perio (gum) Treatment | | |
| Oral Surgery | | |
| Serious Injury to mouth or head | | |
| Osteoporosis/Osteopenia | | |

| **Are your teeth sensitive to:** | **Present** | **Past** | **Never** |
|---|---|---|---|
| Hot / Cold | | | |
| Biting / Chewing | | | |
| Sweets | | | |

**What did you like most about any dental office you have ever been seen in?**

_____

_____

**What did you like least about any dental office you have ever been seen in?**

_____

_____

*Thank you for your answers*