

Patient Name: _____ Date: _____

Please answer the following questions:

1. How often do you brush? _____ How often do you floss? _____
2. Have you ever had bleeding gums? _____
3. Do you have persistent bad breath? _____ Food catching between your teeth? _____
4. What brand of toothpaste do you use? _____
5. Is it important to keep your teeth for as long as possible? _____
6. Do you routinely use a mouthwash? If so, which one _____
7. 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

	<i>Never</i>	<i>Potential</i>	<i>Manifested</i>	<i>History</i>
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				

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			

History

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