DENTAL HEALTH INFORMATION

Patient's Name_____
Last First MI Preferred Name

Complete & honest answers to the following questions will allow Dr. Erdman to treat you on a more individual basis, providing the care appropriate for your *individual* needs. Your answers are for our records only and will be considered CONFIDENTIAL.

1. Are you having any discomfort at this time? Yes No
2. Have you ever had any serious problems associated with previous dental treatment? Yes No
3. Does dental treatment make you nervous? No Slightly Moderately Extremely
4. I think my present state of oral health is: Excellent Good Poor
5. Date of your last dental visit?_____ Service provided _____
6. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No
7. How often do you brush your teeth? _____ Brush is: Soft Medium Hard
8. How often do you floss?_____
9. Do you avoid brushing any part of your mouth due to pain? Yes No If so, what part?_____
_____
10. Do you chew only on one side of your mouth? Yes No If so, please explain: _____
_____
_____
11. Do you have or have you ever had any of the following:

Bleeding, sore gums	Yes	No	Loose Teeth	Yes	No
Unpleasant taste/bad breath	Yes	No	Sensitive to hot	Yes	No
Burning tongue/lips	Yes	No	Sensitive to cold	Yes	No
Frequent blisters on lips/mouth	Yes	No	Sensitive to sweets	Yes	No
Swelling/lumps in mouth	Yes	No	Sensitive to biting	Yes	No
Orthodontic Treatment (braces)	Yes	No	Food impaction	Yes	No
Biting cheeks/lips	Yes	No	Clicking/popping jaw	Yes	No
Difficulty opening or closing jaw	Yes	No			

12. Do you grind your jaws while sleeping? Yes No
13. Do you clench your teeth during the day? Yes No
14. Do your jaws ever feel tired? Yes No
15. Are you wearing removable dental appliances? Yes No
16. Do you have headaches? Yes No
    If yes, how many headaches per week?_____ per month?_____
17. Do you have earaches, neck , or jaw pains? Yes No
18. Do you lose or break fillings? Yes No
19. Do you gag easily? Yes No
20. Do you snore so much each night that your sleep is disturbed? Yes No
21. Do you smoke or use any tobacco products? Yes No
22. Are you unhappy with the appearance of your teeth? Yes No
23. Do you have discolored teeth that bother you? Yes No
24. Would you like your smile to look different or better? Yes No
25. These are things that are important to me about my dental health:_____
_____
26. Please rank from ONE to FOUR in the order that they would keep you from having dental treatment:
    _____ Fear of Pain _____ Lack of concern _____ Cost of treatment _____Missing work time
27. Please use this space to add anything that you feel is important: _____
_____
_____
_____