DENTAL HISTORY

Kurt C. Rolf, DDS

1. Are you having any discomfort at this time? ***YES*** ***NO***

   ____

2. Have you had a serious or difficult problem associated with any previous dental treatment? ***YES*** ***NO***

   ____

3. Does dental treatment make you nervous? ***YES*** ***NO***

   ____

4. Date of your last dental visit? _______________________________________
5. Date of your last dental X-Rays? _____________________________________
6. Have you ever been treated for periodontal disease? ***YES*** ***NO***
7. How often do you brush your teeth? __________________________________
8. Please choose of the toothbrush texture if its:

   ULTRA SOFT ***SOFT*** ***MEDIUM*** ***HARD***
9. Do you use the following?

   ELECTRIC TOOTHBRUSH ***DENTAL FLOSS*** ***FLUORIDE RINSE*** ***TOOTHPICK***
10. Do you have or have you ever had any of the following?

Bleeding Gums	***Unpleasant taste***	***Bad Breathe***
Burning tongue/lips	***Frequent blister,lip/mouth***	***Swelling lump in mouth***
Orthodontic Treatment	***Biting cheeks /Lips***	***Clicking /Popping jaw***
Difficulty open/close jaw	***Loose tooth / teeth***	***Sensitive to HOT / COLD***
Sensitive to SWEET	***Dry Mouth***	***Sensitive to BITING***
Food Impaction	***Clenching / Grinding***	***Shifting /change in bite***

11. Do you wear a removable dental appliance? ***YES*** ***NO***
12. Choose one of the following: My mouth is….

    VERY COMFORTABLE ***MODERATELY COMFORTABLE*** ***UNCOMFORTABLE***
13. Choose one of the following: I think the appearance of my mouth is…

    EXCELLENT ***SATISFACTORY*** ***DISSATISFACTORY***
14. Choose one of the following: it is important for me to…

    KEEP MY NATURAL TEETH ***TIME*** ***MONEY***
15. Choose one of the following: I _____ do what my dentist recommend…

    ALWAYS ***USUALLY*** ***NEVER***
16. Choose one of the following: Dental health is a ______ priority…

    HIGH ***LOW***
17. These are the things that are important to me about my dental health:

    ____

    ____