Please read through and answer the following:

How often do you brush? _____ Do you use a manual or electric toothbrush? _____

How often are you flossing? _____ Do you use a mouth rinse? _____

On a scale from 1 – 10 (1 being the worst and 10 the best), how do you rate your home care? _____

Last dental examination: _____ Last dental cleaning: _____

Chief complaint or main reason for dental visit today:

New Patient Cleaning Broken Tooth (area: UR UL LL LR) Consult: _____

Other: _____

Please circle the following that apply to you:

HEAD

Frequent headaches	Migraines	Tension Headaches
Fatigue/fogginess	Tinnitus	Dizziness/ Vertigo

NECK/BACK

Upper back pain	Fibromyalgia	Joint pain
Limited range of motion	Muscle Atrophy	Muscle pain

THROAT

Difficulty breathing through nose	Choking/shortness of breath	Snoring/ Breathe loud

JAW

Jaw/TMJ Pain	Jaw Popping/Clicking	Clenching/Grinding
Locked In/Restricted bite	Jaw/chin too strong/weak	Limited jaw movement

MOUTH

Gummy smile	Small lips	Large nasolabial folds
Too broad smile	Too Narrow smile	Chronic bad breath

GUMS

Bleeding after brushing	Bleeding after flossing	Black triangles
Receding gums	Swollen/ puffy	Sore/ hurt

TEETH

Yellow/ Dark teeth	Spaces or Gaps/ Pack food	Crooked/ Uneven
Notching near gums	Sensitive to hot/cold	Too Short/ Worn down
Misshapen/ Not centered	Buck teeth/ Stick out	Too Long/ Horsey teeth
Missing teeth	Concerned about silver fillings	Discoloration/Calcification