Neu Family Dental

Personal Dental Health Evaluation

Name (please print) Date

When was your last dental visit?_____
How often did you see the dentist?_____
Do any of the following cause you discomfort?
☐ Hot ☐ Cold ☐ Chewing ☐ Sweets
How often do you….
Brush your teeth?_____
Floss?_____
Rinse with mouth wash?_____

Do your gums bleed while cleaning?	☐ Yes	☐ No
Do your gums feel tender or swollen?	☐ Yes	☐ No
Have you had periodontal gum treatment?	☐ Yes	☐ No
If yes, when? _____		
Do you clench or grind your teeth?	☐ Yes	☐ No

Does your jaw ever….
☐ Feel tired or ache? ☐ Click or pop?

Can you chew on both sides of your mouth?	☐ Yes	☐ No
Comfortably?	☐ Yes	☐ No

Do you have frequent….

Headaches?	☐ Yes	☐ No
Earaches?	☐ Yes	☐ No
Neck and shoulder pain?	☐ Yes	☐ No
Have you ever had orthodontic treatment?	☐ Yes	☐ No
If yes, when? _____		
Do you usually have many cavities?	☐ Yes	☐ No
Do you have noticeable wear on your teeth?	☐ Yes	☐ No
Do you have any areas that trap food?	☐ Yes	☐ No
Do you have any missing teeth?	☐ Yes	☐ No
Have they been replaced?	☐ Yes	☐ No

If so, how? ☐ fixed bridge ☐ removable partial ☐ denture ☐ implants

Are you comfortable with the replacement?	☐ Yes	☐ No
Do you lose fillings or break fillings?	☐ Yes	☐ No
Do you have any cracked or broken teeth?	☐ Yes	☐ No
Have you ever had an unpleasant dental experience?	☐ Yes	☐ No