



# dental history & smile evaluation

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- Do your gums bleed while brushing or flossing?
- Are your teeth sensitive to hot or cold liquids/foods?
- Are your teeth sensitive to sweet or sour liquids/foods?
- Do you feel pain to any of your teeth?
- Do you have any sores or lumps in or near your mouth?
- Have you had any head, neck or jaw injuries?

Have you ever experienced any of the following problems in your jaw?

- Clicking
- Pain (joint, ear, side of face)
- Difficulty in opening or closing
- Difficulty in chewing

- Do you have frequent headaches?
- Do you clench or grind your teeth?
- Do you bite your lips or cheeks frequently?
- Have you ever had any difficult extractions in the past?
- Have you ever had any prolonged bleeding following extractions?

- Have you had any orthodontic treatment?  
If yes, date of placement \_\_\_\_\_
- Do you wear dentures or partials?  
If yes, date of placement \_\_\_\_\_
- Have you ever received oral hygiene instructions regarding the care of your teeth and gums?
- Do you like your smile?

Do you like the way your teeth look?  Yes  No

Explain: \_\_\_\_\_

Would you like for your teeth to be whiter?  Yes  No

Explain: \_\_\_\_\_

Would you like your teeth straighter?  Yes  No

Explain: \_\_\_\_\_

Do you have spaces between your teeth that you would like closed?  Yes  No

Explain: \_\_\_\_\_

Would you like your teeth to be longer?  Yes  No

Explain: \_\_\_\_\_

Do you like the shape of your teeth?  Yes  No

Explain: \_\_\_\_\_

Do you have missing teeth that you would like to replace?  Yes  No

Explain: \_\_\_\_\_

Do you have old silver fillings that you would like to replace with tooth-colored fillings?  Yes  No

Explain: \_\_\_\_\_

If you could change anything about your smile, what would you change?

\_\_\_\_\_  
\_\_\_\_\_

