GRANDVIEW DENTAL
ADAM MCLACHLAN DDS

Dental History

1. What is the reason for your visit today? ____
2. When was your last dental visit? _____________________
3. I routinely see my dentist every:

   ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely
4. Please rate the present condition of your mouth. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**
5. Check if you have a problem with the following:

☐ Bad breath	☐ Grinding teeth
☐ Bleeding gums	☐ Loose teeth or broken fillings
☐ Clicking or popping jaw	☐ Periodontal treatment
☐ Food collection between certain teeth	☐ Sensitivity to any of the following: cold, hot, sweets
☐ Sores or growth in your mouth	☐ Dry mouth
☐ Headaches or migraines	☐ Snoring

6. How often do you floss? ____
7. How often do you brush? _______________________________________
8. Do you use an electric toothbrush? ☐ Yes ☐ No
9. Please rate the appearance of your smile. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**
10. Would you like whiter teeth? ☐ Yes ☐ No
11. Would you like straighter teeth? ☐ Yes ☐ No
12. Have you had orthodontic treatment? ☐ Yes ☐ No
13. Do you wear a bite guard? ☐ Yes ☐ No
14. Do you have a hard time getting numb? ☐ Yes ☐ No
15. Are you aware of any TMJ problems? ☐ Yes ☐ No
16. Would you like to replace silver fillings? ☐ Yes ☐ No
17. Is there anything else that would be valuable for your dentist to know to best care for you?

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