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ESTHETIC COMPREHENSIVE DENTISTRY

PRE-CLINICAL INTERVIEW

Name: _____ Date: _____

PLEASE CHECK YOUR ANSWERS ***(elaborate as necessary)***

1. Do you have pain in your teeth because of heat, cold, sweets or chewing? Yes _____ No _____
   If so, where? _____
   _____

2. Does food catch between your teeth? Yes _____ No _____
   If so, where? _____
   _____

3. Do your gums bleed, either when chewing, brushing, flossing or in general? Yes _____ No _____
   If so, where? _____
   _____

4. Do you chew equally on both sides of your mouth? Yes _____ No _____
   If not, why? _____
   _____

5. Are you aware, or has someone told you that you grind your teeth during the night? Yes _____ No _____

6. Do you clench your teeth during the day? Yes _____ No _____
   Describe? _____
   _____

7. Do you have a tired feeling in your face while chewing, at the end of the day or in the morning when you awaken?
   Yes _____ No _____

8. Do you ever have ringing, pain, popping or clicking in your ears? Yes _____ No _____

9. Do you take large quantities of Aspirin, Tylenol, Advil or other analgesics? Yes _____ No _____

10. Do you have headaches often? Yes _____ No _____ Location: _____
    If so, when? _____
    _____

11. Do you ever have a stiff neck? Yes _____ No _____ When: _____

12. Are you in the habit of biting your fingernails or other hard objects? Yes _____ No _____

13. How much coffee and / or soda do you drink daily? _____ Diet or regular soda? _____

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14. How much sugar do you use? _____

15. How often do you brush your teeth? _____ How often do you floss? _____ Recare interval: _____

16. Have your teeth ever been treated with periodontal surgery or deep cleaning (root planing)?
    Yes _____ No _____ When: _____

17. Have you ever had teeth removed? Yes _____ No _____
    If so, was IV sedation or local anesthetic used? _____ Which do you prefer? _____

18. How long have these teeth been missing? (indicate if wisdom teeth) _____
    _____

19. Did you have them replaced? (excluding wisdom teeth) Yes _____ No _____
    _____

20. Have you ever had local anesthetic (novocain) for a cavity preparation? Yes _____ No _____
    Do you prefer it? Yes _____ No _____

21. Have either of your parents ever had periodontal (gum) disease, bridges, partials or dentures?
    Yes _____ No _____
    Mother: _____
    Father: _____