

# Bay View Dental Care

3380 S. Kinnickinnic Ave.

Milwaukee, WI 53207

Phone: 414-482-2090 Fax: 414-482-0265

## DENTAL HISTORY

Thank you for selecting our dental healthcare team. Please respond to the following dental history questionnaire, designed to open a discussion of your dental concerns. Should you need assistance, we are glad to help.

Your current dental health is:            Good                      Fair                      Poor

Describe your current dental problem(s) or concern(s):

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When was your last dental hygiene appointment? \_\_\_\_\_

What dental aids do you use?            Electric toothbrush            toothpicks            proxibrushes

- |     |    |  |
|-----|----|--|
| Yes | No | Have you ever had root planing (deep cleaning) done?                                     |
| Yes | No | Have you been experiencing pain or discomfort related to your teeth, gums or jaw joints? |
| Yes | No | Do you have a bite plate or mouth guard?   |
| Yes | No | Have you had clicking, popping or pain in your jaw joint or muscles?                     |
| Yes | No | Have you noticed any mouth odors (halitosis) or bad tastes?                              |
| Yes | No | Are your gums red, swollen, glossy or tender?  |
| Yes | No | Do your gums bleed or hurt?  |
| Yes | No | Have your parents ever experienced gum disease or tooth loss?                            |
| Yes | No | Do you frequently experience cold sores, blisters or any other oral lesions?             |
| Yes | No | Have you noticed any loose teeth?  |
| Yes | No | Have you noticed a change in your bite?  |
| Yes | No | Do you clench or grind your teeth while awake or asleep?                                 |
| Yes | No | Have you experienced a serious injury to the mouth or head?                              |
| Yes | No | Would you like to keep your natural teeth for as long as you live?                       |
| Yes | No | Do you get frustrated that you need work done every time you go to the dentist?          |
| Yes | No | Are you satisfied with your teeth's appearance?  |
| Yes | No | Would you like to have whiter teeth?   |
| Yes | No | Would you like your teeth to be straighter?  |
| Yes | No | Do you have metal or discolored fillings that you are unhappy with?                      |
| Yes | No | Do you have crowns or bridges that are unattractive or unnatural-looking?                |
| Yes | No | Do you sometimes feel uncomfortable with the appearance of your smile?                   |
| Yes | No | Do you have unattractive spaces between your teeth?                                      |
| Yes | No | Do you experience headaches, neckaches or shoulder aches?                                |
| Yes | No | Do you have difficulty opening or closing your mouth?                                    |
| Yes | No | Have you ever had periodontal treatment?   |
| Yes | No | Are you apprehensive about dental treatment? If so, what are concerns?                   |

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Signature

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Date