Dr. A. Pavlenko, General dentist

SANADENTAL

Dental and Oral Health Information

Please Describe Any Specific Dental Problem or Discomfort You Are Having At This Time:_____

_____How long has it been present? _____

If you have had any of the following dental care, please list the dentists and approximate dates:

Periodontal (Gum) Treatment or Surgery: _____

"Braces" or any type of Orthodontic treatment: _____

Dental implants: _____

Do you have or had any of the following or noticed any of these signs or symptoms in your head, neck or mouth?

(Please Check Yes or No for Each Question)	**YES**	**NO**		**YES**	**NO**
Teeth that are sensitive to:			A clicking, snapping or difficulty when chewing	__	__
Hot, Cold, Sweets or biting pressure	__	__	Difficulty opening or moving the jaws	__	__
An unpleasant taste or persistent bad breath	__	__	Difficulty speaking or changes in your voice	__	__
Does food catch between your teeth	__	__	Difficulty moving your tongue or "tongue tied"	__	__
Do your gums bleed when brushing	__	__	Loose or separating teeth	__	__
Red, swollen, tender, bleeding or sore gums	__	__	Changes in the way your teeth fit together	__	__
Gums that have pulled away from the teeth	__	__	A colour change of the tissues in your mouth	__	__
Pus between the teeth and gums	__	__	Pain, tenderness, numbness or earaches	__	__
Avoid any area when brushing or chewing	__	__	Any lumps swelling or swollen	__	__
Do you clench or grind your teeth	__	__	Sores, ulcers or rough spots in your mouth	__	__

About your Dental Health:

How do you rate your overall Dental Health? GOOD __ FAIR__ POOR__

How many times a <u>day</u> do you brush your teeth? _____ How many times a <u>week</u> do you floss your teeth? _____

Do you use any of the following? ***(Please check yes or no for each question)***	**YES**	**NO**
Power/Mechanical/Electric Toothbrush	__	__
If yes, what type or brand? Sonicare___ Oral-B/Braun ___ Disposable ___ Other_____		
Flossing Aids (Floss holders, Threaders, etc,)	__	__
Oral Irrigating device (Water Pik)	__	__
Fluoride treatments or supplements at home. If Yes, What: _____	__	__
Mouthwashes or Oral Rinses. If Yes, What Brand? _____	__	__
Do you have any missing teeth that have not been replaced?	__	__
Why have you not had them replaced? _____		
Do you wear any removable dental appliances? If Yes, what type and for how long? _____	__	__
Have you ever had your teeth whitened or bleached?	__	__
Would you like to have your teeth whitened or bleached?	__	__

How do you feel about the appearance of your smile and what would you change if you could?

_____

Are you concerned about the finances required to return your mouth to excellent health?	__	__
Are you frustrated because you always need something treated or repaired when you visit a Dentist?	__	__
Do you feel you will eventually wear dentures?	__	__
Have you ever had any complications from an extraction or dental treatment?	__	__
If yes, please explain: _____		
Have you ever had any other dental conditions, major trauma or injury to your head, neck or mouth?	__	__
If yes, please specify: _____		

If you are a New Patient to this practice:

Date of last Dental visit: _____ Dentist's Name: _____ City & Province_____

Signature: _____Date: _____

Dr. A. Pavlenko, General dentist

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ORAL HEALTH RISK FACTORS

Patient's Name _____Date_____

1 **.Do you smoke or have you EVER smoked**? YES____NO____

(If no proceed to question 2)

The amount that you are presently smoking (Check ALL that apply)

___None(quit smoking completely) ____Less than 1 pack of cigarettes per day ____An occasional cigar

____An occasional cigarette ____1-2 Packs of cigarettes per day ____Cigars on a daily/regular basis

____A few cigarettes per day ____2 of more packs of cigarettes per day ____Occasional pipe smoker

____A pipe on a daily/regular basis

How many years have you or did you smoke?

___Less than 1 year ___Less than 2 years ___2-5 years ___ 5-10 years ___10-20 years ___ Over 20 year

2. **Do you/ Have you EVER chewed tobacco or use/used snuff or other similar substance?**

(If no proceed to question 3) Yes___ No___

Are you STILL using smokeless tobacco or snuff? Yes___ No___

If No WHEN did you quit?

___Less than 6 months ago ___6 months to a year ago ___1 to 3 year ago ___Over 3 years ago

How many years did you use or have you used smokeless tobacco?

___Less than 1 year ___1-2 years ___2-5 years ___ Over 3 years

3. Approximate average amount of alcoholic beverages presently consumed per week

___None ___Less than 1 per week ___1-5 drinks ___6-11 drinks ___11-20 drinks ___Over 20

4. Do you have of have you ever had a substance abuse problem? Yes___ No___

Describe_____

5. Do you presently use any recreational drugs? Yes___ No___

List_____

6. Do you have or have you ever had an eating disorder? Yes___ No___

If Yes, Please Specify_____

7. Do you have or have you ever had any head, neck or mouth piercing(s) Yes___ No___

List_____

8. Do you have of have you ever been informed that you have been infected with an oncogenic strain (possible cancer causing) of the Human Papilloma Virus (HPV)? Yes___ No__

9. Please list your history or any family member's history of cancer _____

_____

_____