KAREN GLERUM D.D.S.
General, Restorative & Cosmetic Dentistry

DENTAL HISTORY

Please check any of the following that apply to you:

Sensitivity (hot or cold) _____ Headaches_____

Teeth or fillings breaking _____ Bad Breath_____

Grinding or clenching teeth _____ Sleep apnea (snoring)_____

Bleeding, swollen, or irritated gums _____ Loose or shifting teeth_____

Who was your previous dentist? Name:_____

Please let us know the dates of: Your last cleaning:_____

Your last oral cancer exam:_____Your last xrays:_____

What are the most important things to you about your smile and dental health?

Do you like your smile? _____yes _____no If you could change your smile, would you: (Check all that apply below)

Make your teeth whiter_____ Make your teeth straighter_____

Replace discolored fillings_____ Close spaces between teeth_____

Repair broken, chipped, worn teeth_____ Replace missing teeth_____

Replace old crowns_____ Have a smile makeover_____

Do your gums ever bleed?_____ How many times do you brush?_____

How many times do you floss?_____What type of brush do you use?_____

Do you smoke or use chewing tobacco? _____ If yes for how long?_____

How important is your dental health to you? 1-5 (5 being highest)_____

How would you rate your current dental health? _____

What is the most important thing to you about your dental visit today?_____

Please indicate any other concerns not specified:_____