James R. Werkmeister DMD, MS
Practice Limited To Periodontics

Dental History

Name: ____________________

Address: ____________________

Who referred you to our office? ____________________

1. Chief Complaint

What concerns do you have about your teeth?

2. Symptoms

Check all boxes that apply to your mouth

- ❑ Hot Sensitive
- ❑ Cold Sensitive
- ❑ Loose Teeth
- ❑ Cavities/Old Fillings
- ❑ Missing Teeth
- ❑ Painful Gums/Teeth
- ❑ Other (describe)
- ❑ Bad Bite
- ❑ Popping/Clicking of Jaws
- ❑ Painful Jaws
- ❑ Food Packing Between Teeth
- ❑ Bad Breath
- ❑ Bleeding Gums

3. Motivation/Interest

Motivation toward keeping your teeth

- ❑ Highly Motivated
- ❑ Somewhat Motivated
- ❑ Not Very Motivated

My main interest in pursuing periodontal treatment is (check the most appropriate box)

- ❑ Keeping my teeth to avoid dentures
- ❑ Maintain a youthful appearance
- ❑ Continue to eat the foods that I want
- ❑ Avoid the health consequences of untreated gum disease
- ❑ Avoid dental pain
- ❑ Because my dentist recommended it

4.Your Dentist/Dental Care

Dentist Name: ____________________

Last dental visit: ____________________

How often do you see your dentist? ____________________

Previous periodontal care: ____________________

5. Oral Hygiene

I brush my teeth________times/day

I floss my teeth ________times/day

Do you use any special oral hygiene aids? (electric toothbrush, proxybrush etc....)