

LAST NAME : _____ FIRST NAME : _____ SEX : F M
 BIRTH DATE : DAY : _____ MONTH : _____ YEAR : _____ TUTOR : _____
 REASON OF THE CONSULTATION : _____
 LEVEL OF DISCOMFORT WITH DENTAL HYGIENE TREATMENT : 0 1 2 3 4 5 6 7 8 9 10

DENTAL HISTORY AND ORAL HABITS

	YES	NO		YES	NO
1. Are you followed by a dentist?			10. Extraction (missing teeth)		
IF YES,			11. Halitosis treatment (bad breath)		
NAME : _____			12. Myofunctional therapy		
Speciality : _____			13. Treatment for the temporomandibular joint		
Frequency of follow-ups : _____ Reason : _____			IF YES,		
Last visit : _____ Last X-rays : _____			Do you wear a nightguard ?		
2. Are you followed by a Dental Hygienist ?			14. Treatment for sleep apnea		
IF YES,			IF YES,		
NAME : _____			Which device do you have ? _____		
Frequency : _____ Last visit : _____			Mandibular advancement device		
Have you had or currently undergoing any of the following treatments :			CPAP (nasal route only) CPAP (full mask)		
3. Periodontics (open or closed curettages, grafts)			15. Fillings		
IF YES,			16. Sealants		
Date of last treatment : _____			17. Teeth whitening		
Were you treated by a periodontist ?			IF YES, method used : At home with custom made trays		
IF YES,			Professionally in clinic Products in pharmacies (OTC)		
NAME : _____			Date of last treatment : _____		
If you are still being followed, frequency of follow-ups : _____			Were you satisfied with the result ?		
4. Orthodontics (braces, removable appliances, aligners)			Do you or have you ever had any of the following habits:		
IF YES,			18. Nail biting		
Date of end of treatment : _____			19. Bruxism ou «clenching»		
Total duration of treatment : _____			20. Cheek or lip biting		
Were you treated by an orthodontist ?			21. Chewing on objects		
IF YES,			22. Thumb sucking		
NAME : _____			23. Do you tend to lean your head on one side ?		
5. Endodontics (root canal treatment)			Do you have any of the following symptoms:		
6. Implantology (single, multiple, implants)			24. Bleeding gums when brushing or flossing		
7. Prosthodontics (bridge, crown, prostheses)			25. Sense of bad breath or bad taste in the mouth		
8. Denturology (denture, full or partial prosthesis up/down)			26. Impacted food in between teeth or areas that floss breaks		
IF YES,			27. Tooth mobility or the feeling that teeth are moving		
Date of the last prostheses : _____			28. Gum pain		
Do you have an attending denturist ?			29. Toothache (hot, cold, sugar, acid, chewing)		
IF YES,			30. Jaw pain or TMJ		
NAME : _____			31. Worn teeth		
Are the prostheses comfortable ?			32. Pain upon awakening		
Do you take off the prostheses to sleep ?			33. Jaw that cracks / jaw that blocks upon chewing or yawning		
Do you use adhesives to hold your dentures ?			34. Difficulty swallowing		
9. Jaw surgery			35. Difficulty breathing through the nose		
IF YES,			36. Difficulty pronouncing certain sounds (lispings, hissing)		
Reason : _____ Year : _____					

Dental Hygiene Routine

YES NO

FREQUENCY

Do you use :

1. Manual Toothbrush
 Compact Regular
 Ultrasoft Soft Mid Hard

2. Electric Toothbrush
 If yes, precise : _____

3. Toothpaste.....
 If yes, precise which one : _____

4. Dental Floss

5. Oral Rinse
 If yes, precise : _____
 Reason of use : _____

6. Prosthesis Brush

Do you use one of the following :

7. Interproximal Toothbrush

8. Rubberized Brush

9. Disposable Floss Holder

10. Reusable Floss Holder

11. Floss Threader

12. Superfloss.....

13. Postcare.....

14. Orthodontic Wax.....

15. Tongue Scraper.....

16. Water Flosser (e.g. Waterpik).....

17. Single-Tuft Brush

18. Sulcus Brush

19. Orthodontic Brush.....

20. Gum Stimulator

Do you use one of the following :

Products against oral dryness (Biotene)

21. Artificial Saliva

22. Oral Rinse

23. Specific Toothpaste

24. Humectant Gel.....

25. Humectant Spray.....

26. Xylitol Chewing Gumc

Cleaning products for prostheses or removable devices

27. Cleaning Tablet (e.g. Polident type or other)

28. Specific Prosthesis Toothpaste (e.g. Polident).....

29. Cleansing Foam (e.g. Polident).....

30. Weekly Cleaner (e.g. Novadent type).....

31. Do you use any other products or objects for cleaning your teeth
 (e.g. toothpicks, homemade recipe)

If yes, precise : _____