Smile Evaluation

Name______________________________________ Date______________________

1. Do you like the appearance of your smile? ☐Yes ☐No
   If no, please explain?____
2. Are your teeth crowded? ☐Yes ☐No If yes, where?________________________________
3. Do you have spaces between your front teeth? ☐Yes ☐No
4. Do you like the color of your teeth? ☐Yes ☐No Would you like a brighter smile? ☐Yes ☐No
5. Do you like the shape of your teeth? ☐Yes ☐No
6. Do you like the position of your teeth? ☐Yes ☐No If no, please explain_____________________________
7. Are you happy with the appearance of your previous dental treatment? ☐Yes ☐No
   If no, explain____
8. Would you like to change the metal-colored dental treatment to tooth-colored esthetic materials?
   Fillings? ☐Yes ☐No Crowns? ☐Yes ☐
   Are you interested in having tooth-colored material for any needed dental treatment? ☐Yes ☐No

9. Do you have any grey or black lines at your gumline under previous crowns? ☐Yes ☐No
   If yes, would you like to improve the appearance? ☐Yes ☐No

10. If you wear a partial denture, do you show a metal clasp when you smile? ☐Yes ☐No ☐NA
    If yes, would you like to have a partial without metal clasps? ☐Yes ☐No

11. How would you like your teeth and your smile to look? Please explain______________________
    ____

12. Inflamed or swollen gums? ☐Yes ☐No

13. History of re-occurring sore spots (canker or cold sores)? ☐Yes ☐No

14. Do you chew only on one side? ☐Yes ☐No Reason:____

15. Do you have any trouble chewing your food properly? ☐Yes ☐No

16. Any bleeding during brushing or flossing? ☐Yes ☐No

17. Does your partial or denture fit well? ☐Yes ☐No ☐NA

18. Would you like to replace your denture or partial denture with a non-removable appliance?
    ☐Yes ☐No ☐NA

19. Have you ever had proper instructions on brushing and flossing? ☐Yes ☐No

20. Do you use a soft brush? ☐Yes ☐No

Children under 12

1. Is there a history of thumb sucking? ☐Yes ☐No If yes, currently thumb sucking? ☐Yes ☐No
2. Is there a history of seeing a pediatric dentist? ☐Yes ☐No
3. Is there a history of nursing bottle decay? ☐Yes ☐No
4. Is there a history of grinding teeth? ☐Yes ☐No
5. Is there a history of facial trauma? ☐Yes ☐No
6. Is there a history of jaw joint problem? ☐Yes ☐No
7. Parents, are you happy with your child's smile? ☐Yes ☐No

TMJ Questionnaire

1. Do you have frequent or regular headaches? ☐Yes ☐No
   Upon awakening? ☐Yes ☐No Late afternoon? ☐Yes ☐No
2. Are your jaw muscles sore or tender? ☐Yes ☐No
3. Are your jaw joints sore or tender when you eat or chew? ☐Yes ☐No
   B. Are your jaw joints sore when opening? ☐Yes ☐No Closing? ☐Yes ☐No
4. Do your jaw joints make any noise such as snapping, clicking or popping? ☐Yes ☐No
5. Do your jaw joints lock when you are trying to open? ☐Yes ☐No Close? ☐Yes ☐No

   A. History of a tooth or teeth breaking or fracturing? ☐Yes ☐No Location of teeth____________

   B. Do you grind or clench your teeth? ☐Yes ☐No If yes, during the day? ☐Yes ☐No
   Or night? ☐Yes ☐No
6. Have you ever worn a splint or nightguard? ☐Yes ☐No If yes, how many______________?
7. Are you taking or have you taken any medications for these symptoms? ☐Yes ☐No
   If yes, please describe____
8. Have you ever seen a dentist or a TMJ specialist for treatment of any jaw joint or teeth clenching problems? ☐Yes ☐No
   Been told that you may grind or clench your teeth? ☐Yes ☐No

   If yes, by whom?____________________________________ Date____________________________