

amersham dental care

NAME: _____

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| 1. Are you suffering any discomfort from your teeth? | YES | NO |
| 2. Do you have a high number of restorations? | YES | NO |
| 3. Do you find every time you attend a dentist you need another restoration? | YES | NO |
| 4. Do you have any complex dental restorations such as implants or bridges? | YES | NO |
| 5. Are you aware of bleeding gums? | YES | NO |
| 6. Have you been told you have periodontal or "gum" disease? | YES | NO |
| 7. Are you aware of bad breath or staining? | YES | NO |
| 8. Do you wear a partial or full denture? | YES | NO |
| 9. If yes are you happy with the fit and appearance? | YES | NO |
| 10. Do you find attending a dental appointment is a nerve racking experience? | YES | NO |
| 11. Are you happy with your smile? | YES | NO |
| 12. Is there anything about the appearance of your teeth you would like to change (e.g the shape or colour)? | YES | NO |
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| 13. Do you play high impact sports? | YES | NO |
| 14. Are you aware of clenching and/or grinding your teeth especially while asleep? | YES | NO |