DiChristofano & DiChristofano
QUALITY DENTISTRY, COMPASSIONATE CARE

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Nutritional History

	Yes	No
1. Are you aware of the dental effects of the food and drink you consume?	☐	☐
2. Do you consume soda or acidified drinks on a regular/daily basis?	☐	☐
3. Do you consume drinks with sugar or corn syrup sweeteners on a regular/daily basis?	☐	☐
4. Do you sip drinks throughout the day? If so, what drinks _____ _____	☐	☐
5. Do you swish your drinks in your mouth before swallowing the liquid?	☐	☐
6. Do you chew ice or hard candy? ----------	☐	☐
7. Do you chew gum? If so, what type? ----------	☐	☐
8. Do you consume mints or candy on a regular/daily basis? ----------	☐	☐
9. Do you drink water that is fluoridated? ----------	☐	☐
10. Do you eat items made from refined white flour (bread, crackers, cookies, pastries) on a regular/daily basis? ----------	☐	☐
11. Do you take vitamin supplements? ----------	☐	☐

I certify that the above information is complete and accurate.

Patient's signature _____ Date _____

Dentist's signature _____ Date _____