Dental Questionnaire

Last First Middle Nickname

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? ☐ Yes ☐ No
2. Have you ever had any serious trouble associated with previous dentistry? ☐ Yes ☐ No
3. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
4. Date of last dental visit: _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ☐ Yes ☐ No
6. Habits. Do you:
   a. Clench or grind your teeth while awake or asleep? ☐ Yes ☐ No
   b. Bite your lips or cheeks or tongue regularly? ☐ Yes ☐ No
   c. Hold foreign objects with your teeth (such as pencils, pipe, pins, nail, fingernails)? ☐ Yes ☐ No
   d. Mouth breathe while awake or asleep? ☐ Yes ☐ No
   e. Do you smoke or chew tobacco? ☐ Yes ☐ No
   f. Do you chew gum? ☐ Yes ☐ No
   g. Do you suffer from bulemia or anorexia? ☐ Yes ☐ No
7. Have you ever had an upsetting experience in a dental office? ☐ Yes ☐ No
8. Is it important to keep your teeth? ☐ Yes ☐ No
9. Are you dissatisfied with the appearance of your teeth? ☐ Yes ☐ No
10. Is there anything else about having dental treatment that bothers you? ☐ Yes ☐ No

Notes:

_____

_____

11. Have you set oral health goals with your previous dentists? ☐ Yes ☐ No
12. Have you always done the best that was recommended for your dental health? ☐ Yes ☐ No
13. Have you put dentistry for yourself and family high on your priority list? ☐ Yes ☐ No
14. Is your present state of dental health good? ☐ Yes ☐ No
15. Do you have headaches? ☐ Yes ☐ No
16. Do you have or have you ever had any of the following:

MOUTH

Bleeding, sore gums ☐ Yes ☐ No
Unpleasant taste/bad breath ☐ Yes ☐ No
Burning tongue/lips ☐ Yes ☐ No
Frequent blister, lips/mouth ☐ Yes ☐ No
Swelling/lumps in mouth ☐ Yes ☐ No
Ortho treatments (braces) ☐ Yes ☐ No

TEETH

Loose teeth ☐ Yes ☐ No
Sensitive to hot ☐ Yes ☐ No
Sensitive to cold ☐ Yes ☐ No
Sensitive to sweets ☐ Yes ☐ No
Sensitive to biting ☐ Yes ☐ No
Food impaction ☐ Yes ☐ No

17. Problems of the jaw. Have you experienced:
   a. Clicking/popping of the jaw? ☐ Yes ☐ No
   b. Pain (joint, ear, side of face)? ☐ Yes ☐ No
   c. Difficulty in opening or closing? ☐ Yes ☐ No
   d. Difficulty in chewing? ☐ Yes ☐ No

18. Do you use the following?

Brush ☐ Yes ☐ No
☐ Soft ☐ Medium ☐ Hard
Fluoride rinse ☐ Yes ☐ No
Dental floss ☐ Yes ☐ No
Toothpick ☐ Yes ☐ No
Water Pik ☐ Yes ☐ No

19. How often do you brush?_____
20. Have you ever had:
   a. Oral surgery? ☐ Yes ☐ No
   b. Your teeth ground or the bite adjusted? ☐ Yes ☐ No
   c. Worn a night guard or other appliance? ☐ Yes ☐ No

21. These are the things that are important to me about my dental health: _____