DENTAL QUESTIONNAIRE

Patient Name: ____________________
Date of Last Dental Visit: __________ Last Dental Cleaning__________ Last Full Mouth X-Ray: __________

Previous Dentist's Name: ____________________
Address____________________ State__________ Zip __________
Telephone ____________________

		Yes	No
1.	Do you have any dental discomfort or concerns? If yes, please describe: ____________________	Yes	No
2.	How often do you have dental examinations? __________		
3.	How often do you brush your teeth? __________ How often do you floss? __________		
4.	What other dental aids do you use (electric toothbrush, toothpick, floss pick, etc.)? __________		
5.	Have you ever had orthodontic treatment? Dentist's Name __________ Treatment Completed On __________	Yes	No
6.	Have you ever had oral surgery? Dentist's Name __________ Treatment Completed On __________	Yes	No
7.	Have you ever had periodontal treatment? Dentist's Name __________ Treatment Completed On __________	Yes	No

8. **Are any of your teeth sensitive to:**
   - Hot or cold? Yes No
   - Sweets? Yes No
   - Biting or chewing? Yes No
9. Have you noticed any mouth odors or bad tastes? Yes No
10. Do you frequently get cold sores, blisters or any other lesions? Yes No
11. Do your gums bleed or hurt? Yes No
12. Have your parents ever experienced gum disease or tooth loss? Yes No
13. Have you noticed any loose teeth or change in your bite? Yes No
14. Does food tend to become caught in between your teeth? If yes, where Yes No
    ____
15. **Do you:**
    - Clench or grind your teeth while awake or asleep? Yes No
    - Bite your lips or cheeks regularly? Yes No
    - Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)? Yes No
    - Mouth breathe while awake or asleep? Yes No
    - Have tired jaws, especially in the morning? Yes No
    - Snore or have any other sleeping disorders? Yes No
16. **Have you experienced:**
    - Clicking or popping of the jaw? Yes No
    - Facial pain (joint, ear, side of face)? Yes No
    - If yes, please describe location.
      ____
      ____
    - Headaches, neck aches, or shoulder aches? Yes No
17. **Have you ever had:**
    - A serious injury to the mouth or head? Yes No
    - If yes, please describe, including cause
      ____
      ____
      ____
18. **If you could change anything about your teeth it would be:**
    - Color Yes No
    - Make them straighter Yes No
    - Replace silver fillings with tooth colored fillings Yes No
    - Repair chipped teeth Yes No
    - Replace missing teeth Yes No
    - Replace old crowns or caps that don't match Yes No
    - Have less gum showing Yes No
    - Be able to chew better Yes No
19. **Do you feel nervous about having dental treatment? If yes, what is your biggest concern?** Yes No
    ____
    ____
    ____
20. **Have you ever had an upsetting dental experience? If yes, please describe.** __________ Yes No
    ____
    ____
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