

# 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.

- Are you having any discomfort at this time?  Yes  No
- Have you ever had any serious trouble associated with previous dentistry?  Yes  No
- Does dental treatment make you nervous?  No  Slightly  Moderately  Extremely
- Date of last dental visit?
- Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?  Yes  No
- How often do you brush? \_\_\_\_\_ Brush is:  Soft  Medium  Hard
- Do you have or have you ever had any of the following?

MOUTH		TEETH	
Bleeding, sore gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unpleasant taste/bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitive to hot	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning tongue/lips	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitive to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent blister, lips/mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitive to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling/lumps in mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitive to biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ortho treatments (braces)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food impaction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Biting cheeks/lips	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clenching/grinding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking/popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, when _____	
Difficulty opening or closing jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shifting in bite	<input type="checkbox"/> Yes <input type="checkbox"/> No

- Do you use the following?
 

Brush	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental floss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fluoride rinse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
- These are the things that are important to me about my dental health: \_\_\_\_\_
- What do you fear most about dental care? \_\_\_\_\_
- Circle one:
 

A. My mouth is	a) very comfortable	E. I	a) have always done the best that was recommended for my dental health.
	b) moderately comfortable		b) have not done what dentists have recommended to
	c) uncomfortable		c) rarely go, and don't care much about having any dental work completed
B. I	a) think the appearance of my mouth is excellent	F. I	a) have put dentistry for myself and family high on my priority list
	b) am satisfied with the appearance of my mouth		b) put dentistry for myself and my family low on my priority list
	c) am dissatisfied with the appearance of my mouth		c) Dentistry is on my list but it's hard to find
C. I	a) will do anything to keep my natural teeth	G. I think my present state of dental health is	
	b) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them		a) Excellent
D. I	a) have set goals for my oral health with a previous dentist		b) Good
	b) want to set goals concerning my dental health		c) Poor
- What are some questions about dentistry and oral health that you have never had adequately answered? \_\_\_\_\_

## DENTAL HISTORY