



DENTAL QUESTIONNAIRE

Date _____
 Last Name _____
 First Name _____
 Preferred to be called / 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 (explain)? _____
 Have you ever had any serious trouble associated with previous dentistry? _____
 Does dental treatment make you nervous? _____
 Date of last dental visit? _____
 Have you ever been treated for periodontal disease, (gum disease, pyorrhea, trench mouth)? _____
 How often do you brush your teeth? _____ Is your brush soft, medium or hard? _____

Do you now or have you ever had any of the following:

MOUTH

- ___ Bleeding sore gums
- ___ Unpleasant taste/bad breath
- ___ Burning tongue/lips
- ___ Frequent blisters on lips/mouth
- ___ Swelling/Lumps in mouth
- ___ Orthodontic Treatment (braces)
- ___ Biting Cheeks/Lips
- ___ Clicking / Popping Jaw
- ___ Difficulty opening of closing jaw

TEETH

- ___ Loose teeth
- ___ Sensitive to Hot
- ___ Sensitive to Cold
- ___ Sensitive to Sweets
- ___ Sensitive when Biting
- ___ Food Impaction
- ___ Clenching / Grinding
- ___ If so, when ? _____
- ___ Shifting in bite

Do you use the following? Brush _____ Floss _____ Fluoride Rise _____ Other _____

These are the things that are important to me about my dental health: _____
 What do you fear most about dental care? _____

- | | |
|---|--|
| <p>1) My mouth is:</p> <ul style="list-style-type: none"> a) very comfortable b) moderately comfortable c) uncomfortable | <p>5) I</p> <ul style="list-style-type: none"> a) have always done the best that was recommended b) have not done what dentists have recommended c) rarely go, and don't care much about having any dental work completed |
| <p>2) I</p> <ul style="list-style-type: none"> a) think the appearance of my mouth is excellent b) am satisfied with the appearance of my mouth c) am dissatisfied with the appearance of my mouth | <p>6) I</p> <ul style="list-style-type: none"> a) dentistry for myself and family high on priorities b) dentistry for myself and family is low on my priorities c) dentistry is on my list but it's hard to find |
| <p>3) I</p> <ul style="list-style-type: none"> a) will do anything to keep my natural teeth b) want to keep my teeth, but have a budget of time and money | <p>7) I think my present state of dental health is:</p> <ul style="list-style-type: none"> a) Excellent b) Good c) Poor |
| <p>4) I</p> <ul style="list-style-type: none"> a) have set goals for my oral health with a previous dentist b) want to set goals concerning my dental health | |

What are some questions about dentistry and oral health that you have and never had adequately answered?

