Dental Questionnaire

NAME_____

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

Date of last dental visit?		
Have you ever had serious trouble with previous dentistry?	Yes ☐	No ☐
Does dental treatment make you nervous?	Yes ☐	No ☐
Are you having discomfort at this time?	Yes ☐	No ☐
Have you ever been treated for periodontal disease (gum disease)?	Yes ☐	No ☐
How often do you brush?		
Is your toothbrush soft ___ medium ____ hard ____?		
DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:		
Bleeding or sore gums	Yes ☐	No ☐
Unpleasant taste or bad breath	Yes ☐	No ☐
Burning tongue/lips	Yes ☐	No ☐
Frequent blisters on lips or mouth	Yes ☐	No ☐
Swelling or lumps in your mouth	Yes ☐	No ☐
Orthodontic treatment (braces, etc.)	Yes ☐	No ☐
Biting cheeks or lips	Yes ☐	No ☐
Clicking or popping jaw	Yes ☐	No ☐
Difficulty opening or closing jaw	Yes ☐	No ☐
Loose teeth	Yes ☐	No ☐
Food impaction	Yes ☐	No ☐
Clenching or grinding	Yes ☐	No ☐
Shifting or change in bite	Yes ☐	No ☐
My mouth is ___very comfortable ___moderately comfortable ___uncomfortable?		
Sensitive to ___ hot ___cold ___ sweets ___ biting ____ not sensitive		
I think the appearance of my mouth is ___excellent ___satisfactory ___poor.		
I think my present state of dental health is ___excellent _____ good ___ poor?		

Signature_____Date_____