# *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. How often do you brush?_____ Brush is: ☐ Soft ☐ Medium ☐ Hard
7. Do you have or have you ever had any of the following?

| MOUTH | | | TEETH | | |
|---|---|---|---|---|---|
| Bleeding, sore gums | ☐ Yes | ☐ No | Loose teeth | ☐ Yes | ☐ No |
| Unpleasant taste/bad breath | ☐ Yes | ☐ No | Sensitive to hot | ☐ Yes | ☐ No |
| Burning tongue/lips | ☐ Yes | ☐ No | Sensitive to cold | ☐ Yes | ☐ No |
| Frequent blister, lips/mouth | ☐ Yes | ☐ No | Sensitive to sweets | ☐ Yes | ☐ No |
| Swelling/lumps in mouth | ☐ Yes | ☐ No | Sensitive to biting | ☐ Yes | ☐ No |
| Ortho treatments (braces) | ☐ Yes | ☐ No | Food impaction | ☐ Yes | ☐ No |
| Biting cheeks/lips | ☐ Yes | ☐ No | Clenching/grinding | ☐ Yes | ☐ No |
| Clicking/popping jaw | ☐ Yes | ☐ No | If so, when_____ | | |
| Difficulty opening or closing jaw | ☐ Yes | ☐ No | Shifting in bite | ☐ Yes | ☐ No |
| | | | Change in bite | ☐ Yes | ☐ No |

8. Do you use the following?

| | | | | | |
|---|---|---|---|---|---|
| Brush | ☐ Yes | ☐ No | Dental floss | ☐ Yes | ☐ No |
| Fluoride rinse | ☐ Yes | ☐ No | ☐ Other_____ | | |

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

_____

10. What do you fear most about dental care?_____

## DENTAL HISTORY