



## Dental Questionnaire

Please answer the following questions to help us understand your unique perspectives, priorities and concerns. You can be assured this information is held in confidence.

What is your immediate dental concern? \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Dentist: \_\_\_\_\_

Have you ever taken an antibiotic before dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had any problems associated with dental anesthetic?  Yes  No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Please rate your comfort level with receiving dental treatment:

No problem  Slight discomfort  Moderate discomfort  Extremely uncomfortable

Have you ever been treated for periodontal disease?  Yes  No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Do you use tobacco products?  Yes  No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

How frequently do you use the following:

Toothbrush  2+ times per day  daily  weekly  bi-weekly  monthly

Dental floss  2+ times per day  daily  weekly  bi-weekly  monthly

Mouth rinse  2+ times per day  daily  weekly  bi-weekly  monthly

Do you currently, or have you ever had any of the following concerns (Please circle one):

C = Current P = Past N = Never

Bleeding gums	C	P	N	Locking of jaw	C	P	N	Food traps	C	P	N
Red / swollen gums	C	P	N	Difficulty opening / closing jaw	C	P	N	Clenching / grinding of teeth	C	P	N
Unpleasant taste / breath	C	P	N	Pain in jaw/muscles	C	P	N	Worn or broken teeth	C	P	N
Burning mouth / tongue	C	P	N	Ringling or fullness in ears	C	P	N	Shifting of teeth	C	P	N
Sores / blisters in mouth	C	P	N	Loose teeth	C	P	N	Uneven bite	C	P	N
Biting cheeks / lips	C	P	N	Sensitivity to hot or cold	C	P	N	TMJ	C	P	N
Orthodontics (braces)	C	P	N	Sensitivity to sweets	C	P	N				
Clicking / popping jaw	C	P	N	Sensitivity to biting	C	P	N				

How frequently do you get headaches? Migraines?

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

*Please Turn Page Over*

*Please answer the following questions with an X on the line.*

How pleased/satisfied are you with your smile?



How pleased/satisfied are you with the shape of your teeth?



How pleased/satisfied are you with the shade (whiteness) of your teeth?



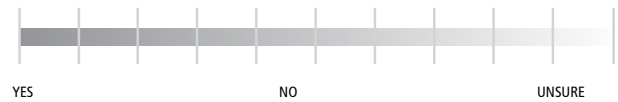
How pleased/satisfied are you with the look of your gums?



Are you aware of having worn or chipped teeth?



Do you have crooked or uneven teeth?



If you answered yes, how much does it affect your smile?



If you answered yes, how interested are you in having dental treatment to correct your teeth?



Is there anything in particular that you would always like us to do for you? \_\_\_\_\_

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What are the things that are important to you about your dental health? \_\_\_\_\_

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Do you have any dental concerns not listed here that you would like to bring to our attention? \_\_\_\_\_

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

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