insight
integrative dentistry

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	Ringing 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?

NOT PLEASED VERY PLEASED

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

NOT PLEASED VERY PLEASED

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

NOT PLEASED VERY PLEASED

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

NOT PLEASED VERY PLEASED

Are you aware of having worn or chipped teeth?

YES NO UNSURE

Do you have crooked or uneven teeth?

YES NO UNSURE

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

NOT AT ALL VERY MUCH

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

NOT AT ALL VERY MUCH

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

_____

_____

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

_____

_____

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

_____

_____

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

_____

_____