Dental Questionnaire

Patient: _____ Age:_____

REASON FOR VISIT AND DENTAL HISTORY

1. What can we do for you? _____

2. When was your last visit to the dentist for a truly complete, detail and accurate examination?
_____

3. Do you remember the name of your previous dentist? _____

4. At your last exam, was there some work that had not been completed or things that were left to "monitor"? _____

5. How often do you usually have your dental exam? _____

6. Is there any particular reason why you are changing dentist? _____

7. On a scale from 0 to 10, what is your level of fear or anxiety about dentistry? _____

8. Is there something in particular that worries you or bother you at the dentist?
_____

TEETH

9. Do you have teeth that are sensitive to: _____

☐Hot	☐Cold	☐Sweet
☐Acid	☐Pressure	☐Chewing

10. Does food get stuck between the teeth or do flossing breaks or holds on to certain places? (CIRCLE) If you circled one or more item, please explain:_____

11. Do you have fillings that have fallen or have cracked? (CIRCLE)
If you circled one or more item, please explain: _____

GUM

12. Do your gums bleed (even a little)? while brushing? while flossing? (CIRCLE)

13. How often on average do you brush and floss your teeth?
Brushing_____ Flossing_____ Mouthwash _____ Adjuvants_____

14. To your knowledge, are there a family member who has had gum disease? YES NO
If yes, please explain:_____

15. Are you confident of your breath or is there occasional bad taste in your mouth? YES NO
If yes, please explain:_____

TEETH FUNCTION

16. Do you restrain yourself from chewing hard food? YES NO
    If yes, please explain:_____

17. Do you feel like you grind or clench your teeth. Do you feel like it does not close equal?
    If you circled one or more item, please explain: _____

18. Are your teeth worn out, cracked or transparent? (CIRCLE)
    If you circled one or more item, please explain: _____

19. Does your jaw locks, crack or makes noise when you chew or yawn?
    If you circled one or more item, please explain:_____

20. Are your teeth or jaw are sensitive in the morning? (CIRCLE)
    If you circled one or more item, please explain:_____

ESTHETIC

21. Have you had orthodontic treatment (braces) and what are / were the retentions?
    If yes, please explain:_____

22. Are you satisfied with the appearance of your teeth esthetically or there is something you would like to improve? YES NO
    If no, please explain:_____

23. Do your teeth have been whitened? _____When? _____How? _____

24. Are you satisfied with the result? YES NO
    If no, please explain: _____

OTHER

25. Is there something else you want to discuss? YES NO
    If yes, please explain:_____
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