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.

Name: ____ **Date:** ______________________

What is your immediate dental concern? ____

Date of last dental visit: ______________________ Previous 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 (gum) 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 a day	___ Daily	___ Weekly	___ Bi-Weekly	___ Monthly
Dental Floss	___ 2+ times a day	___ Daily	___ Weekly	___ Bi-Weekly	___ Monthly
Mouth Rinse	___ 2+ times a 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	Ringing or Fullness in Ears	C	P	N
Red/Swollen Gums	C	P	N	Loose Teeth	C	P	N
Unpleasant Taste/Breath	C	P	N	Sensitivity to Hot or Cold	C	P	N
Burning Mouth/Tongue	C	P	N	Sensitivity to Sweets	C	P	N
Sores/Blisters in Mouth	C	P	N	Sensitivity to Biting	C	P	N
Biting Cheeks/Lips	C	P	N	Food Traps	C	P	N
Orthodontics (braces)	C	P	N	Clenching/Grinding of Teeth	C	P	N
Clicking/Popping Jaw	C	P	N	Worn or Broken Teeth	C	P	N
Locking of Jaw	C	P	N	Shifting of Teeth	C	P	N
Difficulty Opening/Closing Jaw	C	P	N	Uneven Bite	C	P	N
Pain in Your Jaw/Muscles	C	P	N	TMJ	C	P	N

How frequently do you get headaches? ________________________ Migraines? _____________________________

Please describe: ____

PLEASE TURN OVER

Please Answer the Following Questions with an X on the Lines:

<table>
<tr>
<td>How pleased/satisfied are you with your smile?
|--|
Not pleased Very Pleased</td>
<td>How pleased/satisfied are you with the shape of your teeth?
|--|
Not pleased Very Pleased</td>
</tr>
<tr>
<td>How pleased/satisfied are you with the shade (whiteness) of your teeth?
|--|
Not pleased Very Pleased</td>
<td>How pleased/satisfied are you with the look of your gums?
|--|
Not pleased Very Pleased</td>
</tr>
<tr>
<td>Are you aware of having worn or chipped teeth?
|--------------------|---------------------|---------------------|
Yes No Unsure
If you answered yes, how much does it affect your smile?
|--|
Not at All Very Much</td>
<td>Do you have crooked or uneven teeth?
|--------------------|---------------------|---------------------|
Yes No Unsure
If you answered yes, how interested are you in having dental treatment to correct your teeth?
|--|
Not at All Very Much</td>
</tr>
</table>

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?

____

____

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?

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