# Dental Questionnaire

NAME_____

Correct answers to the following questions will allow us to treat you on a more individual basis, providing the appropriate care for your particular needs. Your answers are for our records only and will be considered confidential.

| | | |
|---|---|---|
| Date of last dental visit? | | |
| Have you ever had serious trouble with previous dentistry? | Yes | No |
| Does dental treatment make you nervous? | Yes | No |
| Are you having discomfort at this time? | Yes | No |
| Have you ever been treated for periodontal disease (gum disease)? | Yes | No |
| | | |
| How often do you brush? | | |
| Is your toothbrush soft ____ medium _____ hard _____? | | |
| | | |
| **DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:** | | |
| Bleeding or sore gums | Yes | No |
| Unpleasant taste or bad breath | Yes | No |
| Burning tongue/lips | Yes | No |
| Frequent blisters on lips or mouth | Yes | No |
| Swelling or lumps in your mouth | Yes | No |
| Orthodontic treatment (braces, etc.) | Yes | No |
| Biting cheeks or lips | Yes | No |
| Clicking or popping jaw | Yes | No |
| Difficulty opening or closing jaw | Yes | No |
| Loose teeth | Yes | No |
| Food impaction | Yes | No |
| Clenching or grinding | Yes | No |
| Shifting or change in bite | Yes | No |
| My mouth is ____very comfortable ____moderately comfortable _____uncomfortable? | | |

| |
|---|
| Sensitive to _____ hot _____cold _____ sweets _____ biting _____ not sensitive |
| I think the appearance of my mouth is ____excellent ____satisfactory ____poor. |
| I think my present state of dental health is ____excellent _____ good ____ poor? |

Signature_____Date_____