DENTAL HEALTH QUESTIONNAIRE

*Patient Name*_____ *Date*_____

PRESENT DENTAL CONDITION (Please circle one answer for each category)

Are you having any discomfort at this time?	***None***	***Some***	***A lot***
I think the present state of my teeth is:	***Very Healthy***	***Some disease/decay***	***In poor shape***
I feel the appearance of my smile is:	***Excellent***	***Satisfactory***	***Unsatisfactory***
Improving the health of my mouth is:	***High priority***	***Medium***	***Low***
Improving the appearance of my smile is:	***High priority***	***Medium***	***Low***

If any, what would you like to change about your smile? _____

PAST DENTAL CARE

*Name of previous dentist*_____*Address*_____*Phone*_____
*Date of last visit*_____ *Date of last x-rays*_____

In the past, I have gone to the dentist:	***Regularly***	***Occasionally***	***Emergencies***
The last dental treatment I received was for:	***Exam/Cleaning***		
	Filling/other restoration		
	Emergency care		
I have had problems or pain with past dentistry:	***No***	***Yes/Moderate***	***Yes/Serious***
Dentistry for me and my family is:	***High priority***	***Moderate***	***Low***

Do you have or have you ever had any of the following:

MOUTH:		***TEETH:***	
Bleeding, sore gums	*N___ Y___,when?*	*Loose teeth*	*N___Y___ when?*
Unpleasant taste, bad breath	*N___ Y___, when?*	*Sensitive to hot*	*N___Y___ when?*
Burning tongue or lips	*N___Y___, when?*	*Sensitive to cold*	*N___Y___ when?*
Frequent blisters, mouth or lip	*N___Y___, when?*	*Sensitive to sweets*	*N___Y___ when?*
Swelling or lumps in mouth	*N___Y___, when?*	*Sensitive to biting*	*N___Y___ when?*
Orthodontic treatment (braces)	*N___Y___, when?*	*Food impaction*	*N___Y___when?*
Biting cheeks or lips	*N___Y___, when?*	*Clenching/grinding*	*N___Y___when?*
Clicking or popping jaw	*N___Y___, when?*	*Shifting or change in bite*	*N___Y___ when?*
Difficulty opening or closing jaw	*N___Y___, when?*	*Teeth Whitening*	*N___Y___when?*
Periodontal (gum) disease	*N___Y___, when?*	*Dental Implants*	*N___Y___when?*

HOME CARE

Do you use the following?

Brush	*Y___ N___*	***Dental Floss***	*Y___ N___*
Fluoride rinse	*Y___ N___*	***WaterPik***	*Y___ N___*
Other_____			

How often do you brush? _____ *Brush is:* ___ ***soft*** ___ ***medium*** ___***hard***

FEELINGS ABOUT DENTAL CARE

The thought of dental care makes me: ***Not nervous*** ***Somewhat nervous*** ***Very nervous***
My greatest fear about dental care is? ***Discomfort/Pain*** ***Cost*** ***Time it takes***
What things did you enjoy about your past dental office? _____
What did you dislike about your past dental care/dental office? _____
These are the things that are most important to me about my dental health/dental care:
_____
_____