

Dental Questionnaire

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

1. Are you having any discomfort at this time? Yes No
2. Have you ever had any serious trouble associated with previous dentistry Yes No
3. Does dental treatment make you nervous? No Slightly Moderately Extremely
4. Date of last dental visit? _____
5. Have you ever been treated for periodontal disease?
(gum disease, pyorrhea, trench mouth)
6. How often do you brush? _____ Brush is: Soft Medium Hard
7. Do you have any of the following:

- | | | | | | |
|--------------------------------|------------------------------|-----------------------------|------------------------------|------------------------------|-----------------------------|
| Unpleasant taste or bad breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Denture or Removable Partial | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding, sore gums | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Loose teeth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Smoke or use Tobacco | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitive to hot | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Burning tongue/lips | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitive to cold | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Frequent blisters, lips/mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitive to sweet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swelling/lumps, in mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitive to biting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Orthodontics (Braces) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Food impaction | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Biting cheeks/lips | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Clenching/grinding | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Clicking/popping jaw | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If so, when? _____ | | |
| Difficulty opening/closing jaw | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shifting in bite | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | | | Change in bite | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

8. Do you use the following?

- | | | | | | |
|---------------------|------------------------------|-----------------------------|--------------------------------------|------------------------------|-----------------------------|
| Electric Toothbrush | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dental Floss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fluoride rinse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other <input type="checkbox"/> _____ | | |

These are the things that are important to me about my dental health: _____

What do you fear most about dental care? _____

Circle One:

1. My mouth is
 - a) very comfortable
 - b) moderately comfortable
 - c) uncomfortable
2. I
 - a) think the appearance of my mouth is excellent
 - b) am satisfied with the appearance of my mouth
 - c) am dissatisfied with the appearance of my mouth
3. I
 - a) will do anything to keep my natural teeth
 - b) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them.
4. I
 - a) have set goals for my oral health with a previous dentist
 - b) want to set goals concerning my dental health
5. I
 - a) have always done the best that was recommended for my dental health
 - b) have not done what dentists have recommended to me
 - c) rarely go, and don't care much about having any dental work completed
6. I
 - a) have put dentistry for myself and my family *high* on my priority list
 - b) put dentistry for myself and my family *low* on my priority list
 - c) have dentistry on my list but it's hard to find
7. I think my present state of dental health is:
 - a) Excellent
 - b) Good
 - c) Poor

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