

DENTAL QUESTIONNAIRE FOR _____ (PRINT)

YOUR DENTIST'S NAME _____ FOR HOW LONG: _____

HOW FREQUENTLY HAVE YOU HAD YOUR TEETH CLEANED DURING THE PAST 5 YEARS:

- LESS THAN ONCE A YEAR ONCE A YEAR TWICE A YEAR THREE TIMES A YEAR FOUR TIMES A YEAR

MO/YEAR OF YOUR LAST DENTAL EXAM _____ MO/YEAR OF YOUR LAST DENTAL X-RAYS _____

ARE YOU PRESENTLY SATISFIED WITH THE CONDITION OF YOUR MOUTH AND TEETH (CIRCLE ONE):

- VERY SATISFIED SATISFIED IT'S O.K. SOMEWHAT DISSATISFIED VERY DISSATISFIED

YES NO

- DO YOU PRESENTLY HAVE ANY PAIN, DISCOMFORT OR IMPAIRED FUNCTION RELATED TO YOUR MOUTH?
IF YES, PLEASE DESCRIBE? _____
- ARE YOU CURRENTLY AWARE OF ANY INFECTION IN YOUR MOUTH?
IF YES, PLEASE DESCRIBE: _____
- ARE YOU CURRENTLY TAKING ANY ANTIBIOTICS FOR INFECTION? IF SO, WHAT: _____
- DO YOUR GUMS EVER BLEED? IF SO, WHEN: _____
- DO YOU HAVE A PROBLEM WITH BAD BREATH OR HAVE ANY FRIENDS OR FAMILY MADE YOU AWARE OF THIS?
- ARE YOU INTERESTED IN REPLACING LOST TEETH?
- DO YOU EVER HAVE ACHES OR PAINS IN YOUR JAW JOINTS, EARS, FACE, NECK OR HEAD?
- ARE ANY OF YOUR TEETH TENDER WHEN YOU CHEW HARD FOODS?
- ARE ANY OF YOUR TEETH MORE SENSITIVE TO: COLD, HOT, SWEETS, CERTAIN FOODS OR DRINKS?
- ARE ANY PARTICULAR TEETH VERY SENSITIVE OR PAINFUL? WHEN? _____
- ARE YOU CONCERNED ABOUT GUM RECESSION AROUND ANY OF YOUR TEETH?
- ARE YOU CONCERNED ABOUT THE APPEARANCE OF YOUR TEETH OR MOUTH?
- HAVE YOU EVER HAD ORTHODONTIC TREATMENT? WITH BRACES WITH REMOVABLE APPLIANCES
WHEN DID YOU GO THROUGH ORTHODONTIC CARE? _____
- HAVE YOU EVER RECEIVED PERIODONTAL TREATMENT? SCALING/ROOT PLANING GUM SURGERY
WHEN DID YOU GO THROUGH PERIODONTAL CARE? _____

CHECK ANY OF THE FOLLOWING THAT DESCRIBE YOU OR MAKES DENTAL TREATMENT EASIER FOR YOU:

- I TOLERATE MOST DENTAL CARE REASONABLY WELL AND USUALLY REQUIRE MINIMAL USE OF ANESTHESIA
- I APPRECIATE THE USE OF LOCAL ANESTHETIC – IT ALLOWS ME TO TOLERATE MOST DENTAL CARE REASONABLY WELL
- I TOLERATE SHOTS IN MY MOUTH WHEN THEY ARE GIVEN WELL
- I LIKE THE BENEFITS OF NITROUS OXIDE (LAUGHING GAS)
- I PREFER TO BE SEDATED FOR ANY SURGICAL TREATMENT
- I PREFER TO BE SEDATED FOR ANY LENGTHY SURGICAL CARE
- I HAVE A HARD TIME SITTING IN THE DENTAL CHAIR FOR MORE THAN AN HOUR
- I HAVE A HARD TIME SITTING IN THE DENTAL CHAIR VERY LONG DUE TO A NECK, BACK, SPINE PROBLEM
- I HAVE DIFFICULTY WHEN TILTED BACK IN THE DENTAL CHAIR (DIZZINESS, BREATHING DIFFICULTY, _____)

WHAT ARE YOUR GOALS OR PRIORITIES FOR THE HEALTH, FUNCTION AND APPEARANCE OF YOUR TEETH & MOUTH:

(RATE EACH ITEM FROM 1 TO 5 WITH 1 BEING YOUR LOWEST PRIORITY AND 5 YOUR HIGHEST – YOU CAN USE ANY NUMBER MORE THAN ONCE)

- | | |
|---|--|
| ___ BE ABLE TO CHEW FOOD AND EAT WHAT I ENJOY | ___ AVOID REMOVABLE BRIDGEWORK |
| ___ PRESERVE MY TEETH & AVOID DENTURES | ___ FOR MY MOUTH TO LOOK NICE WHEN I SMILE |
| ___ BE FREE OF INFECTION | ___ MAKE MY TEETH LOOK GOOD |
| ___ BE FREE OF MOUTH PAIN & TENDERNESS | ___ HAVE A HEALTHY AND HASSLE-FREE MOUTH |

Signature of patient or legal guardian

Date

Reviewed by