DENTAL QUESTIONNAIRE

YOUR NAME _____

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 ANTIBIOITICS 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 1TO 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
____PRESERVE MY TEETH & AVOID DENTURES
____BE FREE OF INFECTION
____BE FREE OF MOUTH PAIN & TENDERNESS
____AVOID REMOVABLE BRIDGEWORK
____FOR MY MOUTH TO LOOK NICE WHEN I SMILE
____MAKE MY TEETH LOOK GOOD
____HAVE A HEALTHY AND HASSLE-FREE MOUTH

_____ _____ _____
Signature of patient or legal guardian Date Reviewed by