Date:_____

DENTAL QUESTIONAIRE

Patient Name:_____ Date of Birth:_____

Dental and periodontal disease is caused by a combination of complex factors and the following questions are designed to help us identify them. The success of treatment is dependent upon this. Therefore, although some of the following questions may seem unrelated to your dental condition, they are all associated with proper management of your oral health. Answers to these questions are for our records and will be considered confidential.

If yes, please describe.	Yes	No	Don't Know
1. Do you presently have any dental pain or discomfort?	○	○	○
Please describe: How long? _____			
2. Do your gums bleed?	○	○	○
Where?_____ When?_____			
3. Are you conscious of loose teeth?	○	○	○
4. Do you have problems chewing?	○	○	○
5. Do you have any difficulty (pain, clicking, popping, etc.) in the jaw joints?	○	○	○
6. Date of last visit to dentist?_____ What was done?_____	○	○	○
7. Last cleaning?_____ Frequency of cleaning?_____	○	○	○
8. Have you ever had an unpleasant experience in a dental office?	○	○	○
9. Have you had previous periodontal treatment?	○	○	○
10. Have you had previous orthodontic treatment (braces)?	○	○	○
11. Are you missing any teeth?	○	○	○
When lost?_____ Why?_____			
12. Have you ever had surgery or x-ray treatment for a tumor, growth, or other condition of your head, mouth, or lips?	○	○	○
13. Do you use tobacco in any form? If yes, how long?_____	○	○	○
14. Do you clench or grind your teeth during the day or night?	○	○	○
15. Are you satisfied with the way your teeth look?	○	○	○
16. Previous dentist?_____ How long?_____	○	○	○