Dental History Questionnaire

When was your last dental visit? ____

Have you ever had any problems associated with previous dental treatment? Yes No
If Yes, please explain: ____

How often do you brush your teeth? ____

How often do you floss? ____

Do you routinely use a mouth rinse? Yes No If Yes, how often?: ____________________

Do you experience dry mouth (Xerostomia)?			Yes	No
Do your gums bleed while brushing and / or flossing?			Yes	No
Do you avoid brushing any part of your mouth because of pain or sensitivity?			Yes	No
Do you feel twinges of pain when your teeth come in contact with hot, cold, sweet or sour?			Yes	No
Are any of your teeth sensitive to air or during chewing?			Yes	No
What texture brush do you use?	Soft	Medium	Hard	
Do you chew on only one side of your mouth?			Yes	No
Does food catch between your teeth?			Yes	No
Do you feel your teeth are affecting your health in any way?			Yes	No
Have you ever had professional advice in dental home care?			Yes	No
Do you clench/ grind your teeth while sleeping or during the day?			Yes	No
Do your facial muscles ever feel tired?			Yes	No
Do you wear full dentures?	Upper	Lower	Yes	No
Do you wear partial dentures?	Upper	Lower	Yes	No
Do you have retention problems with your full or partial dentures?			Yes	No
Do you gag easily?			Yes	No
Are you apprehensive (nervous) about dental treatment?			Yes	No
If yes, have you had:	Nitrous Oxide	Medication prior to treatment		

Please add any questions or specific concerns you'd like to review with Dr. : ____________________

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Consent:

The undersigned hereby authorizes the Doctor to perform the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patients' dental or oral facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents.

______________________________ ____________

Patient Signature or Parent / Guardian of Child Date