Dental Questionnaire

Oral Hygiene

•How would you rate your oral health?

1 2 3 4 5 6 7 8 9 10

•Where would you like it to be? _____

•How often do you brush? _____

•How often do you floss? _____

•How often do you clean your tongue?

_____

•Do your gums bleed when you brush?

☐ yes ☐ no

•Have you noticed bad breath, taste or odor?

☐ yes ☐ no

•Have you been treated for Periodontitis?

☐ yes ☐ no If yes, when?_____

•Have your parents experienced gum disease or tooth loss?

☐ yes ☐ no

•Have you experienced tooth loss?

☐ yes ☐ no

If yes, how did that make you feel?

_____

•Do you feel that it is possible to keep your teeth for a lifetime?

☐ yes ☐ no

Biting Surface

•Do you have any of these TMJ or jaw symptoms when you chew?

☐ Popping/Clicking ☐ Clenching/Grinding

☐ Soreness/Discomfort

☐ Limited jaw opening/Stiffness/Locking

•Is your bite comfortable? _____

•Do your teeth fit together when you bite?

_____

•Have you noticed any wear on your teeth?

_____

Clinical

•Do you have any teeth that are:

☐ Missing ☐ Broken/ Chipped ☐ Loose

☐ Sensitive ☐ Missing Restorations

•Have your wisdom teeth been removed?

_____

•Have you whitened your teeth? _____

Cosmetic

•What are your goals concerning your oral healthcare and your smile?

☐ Function ☐ Esthetic ☐ Both

•Looking in the mirror, how would you rate your smile?

1 2 3 4 5 6 7 8 9 10

•Where do you want it to be? _____

Sleep

•Have you been told that you snore?

☐ yes ☐ no

•Have you ever been diagnosed with Sleep Apnea?

☐ yes ☐ no

•Are there any experiences in your dental history you would like for us to know?

_____

_____

_____

•What would you like us to focus on?

_____

_____

_____

Name: _____ Date: _____