Dental & Health Questionnaire

Name _____ Date _____

DENTAL HISTORY

What brought you in to see us today? _____
Have you ever had trouble , problems or anxiety with previous dental care? ___yes ___no
If so, please explain_____

Former Dentist _____
Name Address City, State, Zip Phone #
Date of last dental visit _____ Last x-rays _____
Frequency of dental cleanings _____ x year
Hygiene aids used at home: Type of toothbrush_____ frequency of use _____
Floss use ___yes ___no ___infrequent
Do you notice bleeding when you brush or floss? ___yes ___no
Have you ever been treated for Periodontal "gum" Disease? ___yes ___no
Do you have any mercury-based (silver or amalgam) fillings? ___yes ___no
Do you have or have you ever had:

Bleeding, swollen or sore gums	___yes ___no	Fractured or broken teeth/fillings	___yes ___no
Unpleasant taste or bad breath	___yes ___no	Loose teeth	___yes ___no
Burning tongue or lips	___yes ___no	Sensitivity to cold, heat or sweets	___yes ___no
Frequent cold sores or blisters	___yes ___no	Dry mouth	___yes ___no
Swellings or lumps in mouth	___yes ___no	Food catching between teeth	___yes ___no
Frequent biting of cheek, lips or tongue	___yes ___no	Wisdom teeth removed	___yes ___no
		Prolonged bleeding	___yes ___no
Orthodontic treatment (braces)	___yes ___no	A serious accident involving the head, neck or face	___yes ___no
TMJ or jaw problems	___yes ___no	Nicotine use (smoking or chew)	___yes ___no
Awareness of clenching or grinding	___yes ___no	____packs/day over ___ years	

Are there any other dental problems or issues that have not been covered above? _____
Is there anything you would like to do to change the appearance of your teeth? _____

HEALTH HISTORY

Is your general health good? ___yes ___no
Has there been a change in your health within the last five years? ___yes ___no
If so, please explain _____
Are you under the care of a medical practitioner? ___yes ___no
If so, for what condition? _____
Name, address and phone # _____
of medical practitioner _____(____)_____
Are you taking any medications or supplements?
If so, please list: _____
_____
_____
_____

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